



CITY OF ABERDEEN.

REPORT

BY THE

MEDICAL OFFICER OF HEALTH

FOR THE YEAR

1954

ABERDEEN:

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MCMLV.

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CITY OF ABERDEEN.

SUMMARY OF STATISTICS.

The following is a summary of the principal statistics for the years 1949-54:—

	1949.	1950.	1951.	1952.	1953.	1954.
Population estimated to middle of year	189,314	187,961	183,248	183,626	185,232	185,725
Marriage-rate per 1,000 population .	9.7	9.9	10.0	10.5	10.4	10.2
Birth-rate per 1,000 population .	17.5	17.2	16.5	16.5	16.6	17.4
Illegitimate birth-rate per 100 births	5.7	5.3	5.4	5.7	4.5	4.3
Still-birth rate per 1,000 total births	19	22	21	18	20	19
Infant mortality rate per 1,000 live births	30	29	27	30	27	22
Neo-natal mortality rate per 1,000 live births	16	17	18	18	19	15
Death-rate per 1,000 population .	11.7	12.1	11.9	11.7	11.3	11.1
Malignant diseases death-rate per 1,000 population	1.82	2.08	1.95	2.28	2.00	1.80
All tuberculosis death-rate per 1,000 population	0.35	0.23	0.22	0.22	0.16	0.12
Respiratory tuberculosis death-rate per 1,000 population	0.32	0.20	0.20	0.20	0.14	0.10
Principal epidemic diseases death-rate per 1,000 population	0.06	0.09	0.08	0.03	0.02	0.03
Average age at death (in years) .	64.1	64.9	65.7	64.6	65.1	66.3

PREFACE.

It is a little difficult to discuss the health of the City and the development in its health and welfare services in 1954 without appearing to be guilty of complacency. To remove any suggestion of smugness, two statements must be made right at the start of this report.

The first statement is that many of Aberdeen's vital statistics still compare unfavourably with those of a number of English cities and even more unfavourably with those of cities in the Scandinavian countries. In fairness, however, it should be added that Aberdeen shares with Glasgow the distinction of having an unusually large proportion of its population in the poorest social class, and that the housing circumstances of the City, despite rapid progress in recent years, are still, in many respects, worse than those of other Scottish cities and very much worse than those of most English cities.

The second statement is that many highly desirable developments of the Health and Welfare Department remain things of the future (*e.g.*, the adequate expansion of the dental section, the creation of a health education section, the provision of more services for cripples, and the establishing of occupation centres for mental defectives).

Nevertheless, 1954 was a remarkable and memorable year, as is evinced by the following points:—

1. The increase in the average age at death, which rose above 66 years for the first time in the history of Aberdeen.
2. The fall in the infant death-rate to a figure far lower than any ever previously recorded for Aberdeen and below the lowest figure hitherto chronicled for any Scottish city.
3. The decrease in the number of deaths of children aged 1-5 years to less than two-thirds of the lowest number recorded in Aberdeen in any past year, and a considerable decrease in the number of deaths in children of school age.
4. The drop in the total loss of young lives (*i.e.*, still-births, infant deaths, and deaths of pre-school and school children) to the lowest figure yet recorded.
5. The decrease in the illegitimate birth-rate to a figure lower than the 1953 low record.
6. The drop in the percentage of deaths occurring in persons under the age of 45 years from the record low figure of 11 in 1953 to a new low record of 9, and the increase in the percentage of deaths occurring in persons over the age of 75 years to a new high record of 39.
7. The drop in the tuberculosis death-rate to a figure considerably lower than that which, in 1953, was termed "almost unbelievably low."

8. The complete absence of home accidents as a cause of death in children aged 1-15 years (the age-group in which it was previously the leading cause of death)—an absence presumably associated with the home safety campaign conducted during the year.
9. The complete absence of diphtheria from the City for the second successive year.
10. An increase by more than 100 per cent. in the number of elderly persons being visited by health visitors, an increase by more than 100 per cent. in the number of attendances at post-natal clinics, an increase in the number of attendances at ante-natal clinics, an increase in the number of children brought to child welfare clinics, an increase in the number of school health inspections by health visitors, an increase in the number of re-inspections of school children by medical officers, and an increase in the number of dental inspections of children.
11. The introduction of a post-qualification course of training in mental health work for health visitors.
12. The number of important developments in the services initiated during the year.
13. The very considerable amount of research work carried out in the Department.
14. The awards conferred on several members of staff.
15. The number of articles published by members of staff in professional journals; and
16. The number of addresses given by members of staff to national conferences.

The annual report here presented deals with the health of the City and the activities of the Health and Welfare Department during 1954, except that the portion relating to the school health service covers the school year 1953-1954. In general, the chapter headings and layout follow lines similar to those used in the reports for 1952 and 1953, and (as in the report for 1953) there have been introduced, for the convenience of those who may not wish to read each chapter in its entirety, paragraphs at the beginning of the various main sections briefly outlining the principal features of the year and any major changes that have occurred.

This preface will be divided into five portions, dealing respectively with the health of the City, the chief developments during 1954, staff increases in recent years, awards and publications, and a tribute to a great leader.

THE HEALTH OF THE CITY.

There are three ways in which health can be assessed. The most satisfactory way of all is by devising and employing actual measurements of health, since health is something far more than just absence of disease. However, civilisation has not as yet progressed far enough to carry such measurements of health beyond a very

early, experimental stage. The second method of estimating health is by the study of the prevalence and types of diseases in a community. As yet, however, the amount of information about morbidity available to medical officers of health is limited. Consequently, for indices of health we still have to fall back in general on the third method—assessing the health of a community by studying the various death-rates.

On the whole, the death-rates, when intelligently used, can provide a reasonably good indication of the health of a community and of the state of its health services. Where the numbers of deaths in the various groups (infant deaths, deaths from tuberculosis, &c.) have become low, the rates are, however, inevitably subject to the vagaries of statistical chance: one expects a slight year-to-year variation. It so happened that the vital statistics of Aberdeen for 1953 had been, on the whole, the best previously recorded: for example, in that year the tuberculosis death-rate and the infectious diseases death-rate had both been not merely new low records, but very far below the lowest figures previously charted for the City; the illegitimate birth-rate had fallen to a new low record; the infant mortality rate had been as low as the lowest figure ever previously chronicled; the number of deaths below the age of 45 years had declined; and the average age at death had risen. In view of the eminently satisfactory nature of the vital statistics for 1953, one might well have expected that the figures for 1954 would have shown no improvement, and one might even have expected that some of these figures would have shown an apparent slight retrogression through chance variation. In point of fact, however, the figures for 1954 are so much better than those for 1953 as to be almost unbelievable.

The year 1954 has completely eclipsed 1953 and has set up a large number of new health records for the City. While Aberdeen has shared with other places a gradual increase in the standard of living over the last 20 years, and while housing has made rapid progress in recent years, the new health records—which are the more significant because, during 1954, the cost of living was increasing and climatic conditions were, on the whole, rather unfavourable—must be attributed in large measure to two things—(a) the policy pursued by the Health and Welfare Committee of increasing the number of its disease-preventing officers, and (b) the enthusiastic, conscientious, and devoted work of departmental medical officers, health visitors, midwives, sanitary inspectors, and other members of the staff of the Health and Welfare Department.

Since children are the most valuable asset that any community can possess, pride of place must be given to information about the health of children. The **infant mortality rate**, which is still regarded as the most sensitive index of the health and health service of a community, has fallen from 30 per thousand live births in 1952, and 27 per thousand in 1953, to 22 in 1954. When the infant deaths are divided into those occurring in the first month of life and those occurring in the next eleven months, it is found that the rate for the former is now 15.4 (representing 50 deaths) while that for the latter has reached the remarkably low figure of 6.2 (representing 20 deaths). Both rates are, of course, new low records.

THE LOW
RECORDS
OF 1953.

THEIR ECLIPSE
IN 1954.

INFANT
DEATH-RATE.

It is pleasant to be able to state that there were only 70 infant deaths during the year, as compared, for instance, with 84 in 1953, 90 in 1952, 169 a decade ago, and 235 twenty years ago. There is, however, ample room for future improvement. Infant death-rates substantially lower than the Aberdeen figure are recorded in parts of Sweden, Norway, Russia, and New Zealand, and in some areas in England.

Some forty-five years ago, the Medical Officer of Health, Professor Matthew Hay, made the bold statement that he saw no reason why the infant mortality rate should not fall to 70 per thousand live births. To-day, in view of the higher standards of living and in view of the fact that there is available for every household the skilled advice of the family health visitor, supplemented where necessary by the skills of the family doctor, the public health medical officer, and the pædiatrician, the writer of this report can see no reason why the infant mortality rate should not fall below 17 per thousand live births.

There were 8 **deaths in children aged 1-5 years**, the lowest number previously recorded in any year being 13 in 1952. The report for 1953, after mentioning that 4 of the 19 deaths in this age-group were the results of home accidents, continued—

“Apart from two deaths ascribed to tuberculous meningitis, no deaths in this age-group were caused by infectious diseases. The conquest of infection constitutes a remarkable triumph; the prevalence of accidents offers a challenge to all health workers.”

In 1954, there were three deaths ascribed to tuberculous meningitis, one to meningococcal infection, and no other deaths in this age-group caused by infectious diseases; one death was the result of a road accident, and **no deaths were due to home accidents.**

CAUSES OF FALL IN CHILD DEATHS.

Those who are interested in the causes and extent of the decline in infant and pre-school deaths may care to have their attention directed to chapter 2 of this report. A sub-section entitled “Decline in Infant and Pre-school Deaths” gives figures for a period of fifty years and sets out nine of the main causal factors.

DEATHS OF SCHOOL CHILDREN.

There were 11 **deaths of children of school age**, as compared with 15 in 1953. None of the deaths was due to infectious diseases or home accidents.

ILLEGITIMACY RATE.

A remarkable feature of the last two years has been the sharp **decrease in the illegitimate birth-rate.** In 1953, it fell to 4.5 per cent. of all live births, which was by far the lowest figure recorded in Aberdeen. In 1954, it has fallen to 4.3 per cent. of all live births. Here again, however, there is ample room for improvement and no cause for complacency. It is worth mentioning that 1953 and 1954 are the only years in which the Aberdeen figure has been below the national average.

STILL-BIRTH RATE.

In view of increases in the cost of living it was expected that the **still-birth rate** would be higher in 1954 than in 1953. In actual fact, however, the rate for the year was 19 per thousand total births (as compared with 20 in 1953)—a fact for which considerable credit is due to all persons concerned with ante-natal and obstetrical care.

There were two deaths from causes related to pregnancy and childbirth, as compared with seven in the previous year. MATERNAL MORTALITY.

In 1952, over twelve per cent. of all deaths were in persons under the age of 45 years; in 1953, the percentage fell to 11; in 1954, it has dropped to 9. Analysis by cause shows that the biggest reduction of deaths in this age-group was in fatalities due to **violence**: a reduction from 40 deaths in 1953 to 19 in 1954. DEATHS UNDER AGE OF 45.

The percentage of deaths occurring in persons over the age of 75 years continues to increase—37 per cent. in 1952, 38 per cent. in 1953, and 39 per cent. in 1954. The gradual but steady increase in the **average age at death** (from 64·6 years in 1952 to 65·1 years in 1953, and 66·3 years in 1954) is to a considerable extent a measure of health and social progress, although it inevitably brings with it many problems characteristic of an ageing population. DEATHS OVER AGE OF 45.

The **tuberculosis death-rate** (which, like the infant mortality rate, is generally accepted as a fairly sensitive index of the health of a community) reached a new low level of 0·16 per thousand population in 1953 and has now fallen still further to 0·12 per thousand. TUBERCULOSIS DEATH-RATE

The mortality rate from the **principal infectious diseases** was 0·03 per thousand population, as compared with 0·02 in 1953 and 0·03 in 1952. There were no cases of diphtheria for the second successive year, and there were decreases in the numbers of most notifiable diseases except poliomyelitis and dysentery. DEATH-RATE FROM INFECTIONS.

After the various mortality figures given above, all of which show—to such extent as it is possible to assess health in terms of deaths—that the health of the City is better than ever before, it seems a pity to end this section on a carping note. Yet an enormous amount can be done in the future to make the health of the community even better. For example—

(a) The increase of **poliomyelitis** constitutes a challenge that can be met in two ways—by the development of a form of specific immunisation (a task on which workers in various countries are already engaged) and by detailed study of the epidemiology of the disease. Such study will need to be undertaken on a national basis: with only 18, 12, and 34 cases in three successive years, a city of the size of Aberdeen cannot usefully undertake a special investigation.

(b) The increase of **dysentery** constitutes another challenge. One wonders whether an intensive food hygiene campaign (conducted with the same energy and enthusiasm as the 1954 Home Safety Campaign) would not contribute materially to the reduction of the disease. Unfortunately, there is a grave shortage of health visitors, on whom must fall the brunt of any educational campaign, and there is also a shortage of sanitary inspectors.

(c) The fact that 11·7 per cent. of school entrants in 1953-54 were found at medical examination to have serious defects emphasises the need for even more attention to child welfare. There are some areas of the City (*e.g.*, Northfield,

Mastrick, and Holburn) not yet provided with **child welfare clinics**, and the mobile unit cannot effectively serve all such districts. Again, while Aberdeen has already done well in the provision of attractive permanent clinics and the institution of an appointments system, some clinics (*e.g.*, that at Castlegate) are in urgent need of replacement by well-designed modern buildings. It has to be remembered that, while clinics are no substitute for the home visits of the family health visitor (or, during illness, the home visits of the general practitioner), they are nevertheless extremely useful, and their scope is tending to broaden considerably.

(*d*) Wide **extension of health education** is desirable, and it will probably be necessary to establish a health education section of the Health and Welfare Department. A great deal of very useful health education could be undertaken at the ante-natal clinics where the expectant mother is often in a particularly receptive mood; but little is yet being done. At the full-time child welfare clinics, health visitors give weekly talks and medical officers give monthly talks, but many developments could profitably be undertaken. In the schools, the health visitors are certainly not being used for health education of groups and the mothercraft teachers are few in number as well as probably being inevitably out of touch with modern developments in the field of health promotion (*e.g.*, in respect of emotional and mental aspects). Health education of adolescents is again almost virgin soil. Health education of the elderly is a subject still in its infancy, although a study day held in 1954 may have helped to equip health visitors more adequately for this work.

(*e*) **More health visitors** are urgently required. Now that the health visitor has taken her place as the health counsellor of the family, with the duty of teaching and guiding individuals and families to become physically and mentally healthier by their own efforts; now that she is recognised as playing a part in the prevention of disease similar to that of the general medical practitioner in the treatment of sickness; now that she is established as the basic medico-social worker and "the spearhead of the social service"—it is more important than ever that her case-load be reduced to such a level as will enable her to know each of her families really well. It is a tragedy that, when a city like Aberdeen has the wisdom to increase its establishment of health visitors, there are no candidates for vacant posts. Until such time as the remuneration and conditions of service of the health visiting profession are substantially improved, shortages of staff will continue to interfere with the adequate development of the disease preventing and health promoting service.

(*f*) While the furnishing and equipment of the **health visitor training school** was to some extent improved during the year, there is urgent need for more adequate and more suitable accommodation.

(*g*) Development of the **dental service** is badly needed. In 1954, there was still virtually no service for expectant mothers and pre-school children, and a mere skeleton of a service for school children.

(h) Apart from additional child welfare clinics and a new health visitor training school, **accommodation** is urgently required for a recreational centre for physically handicapped persons, for an occupation centre for ineducable mental defectives, for a deafness detection clinic, and for an orthoptic clinic.

DEVELOPMENTS DURING 1954.

Some of the main developments are briefly indicated below.

(1) **Training of health visitors for mental health work.** In the opinion of the writer of this report, this is incomparably the most important development during any recent year. Indeed, when regard is had to the potentialities of this development, things like the introduction of immunisation against diphtheria (locally in 1925 and nationally in 1941) and the starting of immunisation of school children against tuberculosis (locally in 1953 and nationally in 1954) fade into relative insignificance.

The increasing prevalence of diseases of mental and emotional origin constitutes a real menace to our civilisation. Already mental diseases and mental deficiency between them take up nearly half the beds provided by Regional Hospital Boards; already the neuroses constitute the commonest cause of absence from work; already an incalculable amount of suffering and distress is created by psychosomatic diseases; and to these can be added a vast number of cases of abnormal and anti-social behaviour—chronic alcoholism, drug addiction, juvenile delinquency, petty crime, sex perversions, prostitution, &c. "Treatment of a fully developed case of psychoneuroses involves the expenditure of much time and much money. We in Britain have not enough doctors, not enough nurses, not enough hospital beds, not enough money for the effective treatment of even the visible portion of this vast iceberg. Unless we can reduce the prevalence of these conditions by preventive measures, the outlook is dismal indeed."

It is becoming appreciated that at least one half of all human disease and suffering has its origin in faulty emotional relationships, especially in childhood; and that measures designed to improve such relationships are imperative if our civilisation is not ultimately to be swamped by the rising tide of anxiety states, obsessions, depressions, hysterics, sex perversions, delinquency, and crime. It is also becoming appreciated that **the member of the community in the best position to undertake mental health teaching of parents and prospective parents is the modern, recently trained, family health visitor.** Indications of this appreciation are found, for instance, in a circular issued on 4th December, 1954, by the Secretary of State for Scotland, pointing out among other things that the health visitor's work "now extends to cover the whole field of prevention of ill-health, including prevention of mental ill-health," and that she should receive information about signs of family difficulty from general practitioners, home nurses, hospitals, and schools; in similar statements made in England and Wales by the Minister of Health; and in the stress laid on the work of the health visitor in a recent detailed study by a London working party (which consisted of public health medical officers, psychiatrists, health visitors, and a psychiatric social worker).

NEED FOR
PREVENTION
OF MENTAL
AND
EMOTIONAL
DISEASE.

INCREASING
RECOGNITION
OF ROLE OF
HEALTH
VISITOR.

To say that the modern family health visitor is in the best position to undertake mental health teaching is in no way to disparage either the public health medical officer or the family doctor, both of whom can also give valuable help. The health visitor has, however, certain specific advantages—

(a) in her training she receives considerably more instruction about normality than does the doctor taking a D.P.H. course as a preliminary to a career in public health, and in her work she obtains an unrivalled knowledge of the normal;

(b) in her training she nowadays receives a course of instruction in teaching methods, whereas her medical colleague receives no such instruction; and

(c) in her work she has the tremendous advantage of visiting families in their own homes while they are still healthy (before a faulty situation exists), whereas the public health medical officer sees the mother and healthy child in the rather less informal atmosphere of the clinic, and the general practitioner is under the disadvantage that he usually visits the home only after a faulty situation has occurred (when the need for treatment has arisen).

In general, the modern, recently trained health visitor has the knowledge and the teaching skill to help parents and prospective parents to appreciate more fully the emotional needs of children—*e.g.*, the need not merely for affection but for demonstrated affection, for consistency and security, for a proper balance between over-strictness and over-licence, and for the measures that can prevent sibling rivalry.

Relatively little of this help has been given to parents and prospective parents as yet, for two reasons.—In the first place, there have been grave shortages of staff: in mental health of all things, the teacher must have a close knowledge of the persons taught: it is quite hopeless for a health visitor to try at an infrequent visit to show a young mother that she is over-protecting her adventurous toddler or that she is demanding from a two-year-old the behaviour standards of a normal three-year-old. In Aberdeen, staff shortages are gradually being overcome. In the second place, many of the older health visitors—although they too have an unrivalled knowledge of normality and are in many cases good practical psychologists by reason of their experience—received during their training insufficient teaching in the psychology of development to be able to profit fully from recent advances in that science. To try to overcome this difficulty, the Health and Welfare Department has been a pioneer in organising a **post-qualification course in mental health**. Twenty health visitors attended this course in 1954, and it is hoped that a further twenty will attend a similar course in 1955.

This endeavour to equip health visitors more fully for their important duties in the field of mental health should in course of time lead to considerable improvement in parent-child relationships and to an appreciable reduction in such conditions as psychoneurotic and psychosomatic diseases, delinquency, and petty crime.

Much more is, of course, desirable: one would like to see the health visitors even better trained for this work, and one would also like to see (whether by alteration of the D.P.H. course or otherwise) doctors who intended to specialise in public health given some instruction in teaching; but at least an excellent start has been made.

(2) **Prevention of accidents in the home.**—In recent years, domestic accidents have become one of the leading causes of death and disability in children; indeed, in certain age-groups, home accidents are the numerically largest cause of death. In adults, home accidents are quite frequent, and at the upper end of life they are very frequent and often serious. Although further research into the causation of domestic accidents is desirable, enough is already known to permit of the application of preventive methods.

In view of these facts, a decision was taken to apply to the problem of home accidents the well-tried techniques of health education. The campaign consisted essentially of three parts—

(a) To focus public attention on home accidents and on the possibility of preventing them in large measure, a **Home Safety Week**, carefully organised, and conducted with the maximum amount of publicity obtainable. The Aberdeen Home Safety Week was, incidentally, the first of its kind, although, before the end of 1954, Stirlingshire and London County Council had also held Home Safety Weeks. (Details are, of course, given in the body of the report, under the heading of Health Education.)

(b) Less flamboyant but probably even more important, the quiet, unobtrusive work of health visitors and other health workers **in the homes of the people**—pointing out potential causes of accidents and reiterating the lessons of Home Safety Week in the ways most suitable for the individual addressed.

(c) As a follow-up, **an illustrated book on Home Safety**, produced without any cost to the Corporation. (At the end of 1954, this book was not yet available but was in process of being printed.)

It is perhaps too early to assess the success of a campaign which only began in May, 1954, although it can be said that the main meetings were remarkably well attended, that the rhyming slogans distributed over the town appeared to catch the public fancy, that the whole complex operation went off without a single hitch, and that the decline in the fraction of the death-rate ascribed to violence and the complete absence of deaths from home accidents in the age-group 1-15 years may be an early indication that the campaign has not been without effect. The total cost of the Home Safety Week was only £208, or less than the total cost to the community of two serious accident cases each in hospital for seven weeks at £15 a week.

Not the least important aspect of the home safety campaign is that it has, once and for all time, dispelled the formerly prevalent idea that the proper sphere of

health education is simply hygiene and the prevention of infectious diseases: the prevention of infections, while undcultedly important, comprises only one portion of the vast subject of health education.

TESTING FOR RHESUS FACTOR.

(3) **Increase in ante-natal clinic sessions.**—During 1954, the weekly number of ante-natal sessions was raised from 8 to 10. This increase made it possible to examine the blood of all expectant mothers (instead of selected cases) for the Rhesus factor.

It may be appropriate to mention here that the number of attendances at the ante-natal clinics rose in 1954 above the already high figure for 1953, that the number of attendances at the post-natal clinics more than doubled, and that there was also an increase in attendances at the gynæcological advisory clinic.

HOLBURN AND NORTHFIELD CLINICS.

(4) **New Child Welfare Clinics.**—A start was made during the year in the building of a child welfare clinic at Holburn and a child welfare and school health clinic at Northfield.

It may be mentioned that more children were brought to child welfare clinics in 1954 than in any previous year.

RESEARCH— CHILD HEALTH.

(5) **Detailed study of children born in 1953.**—During the year, a detailed study was continued of all children born in the previous year.

RESEARCH— IMMUNISATION.

(6) As mentioned in more detail later, the department secured a research grant to pay in full for the cost of a long-term investigation of the efficacy of **combined immunisation** against diphtheria, whooping cough, and tetanus.

RESIDENTIAL NURSERIES.

(7) An extension to **Pitfodels Residential Nursery** was completed during the year, and the small nursery at **Thorngrove** was closed. (After alteration, the latter will be used as a home for old people.)

DAY NURSERIES.

(8) An extension to one of the Corporation's four **Day Nurseries** (Deeside) was completed during 1954.

HEALTH VISITORS.

(9) Although (as mentioned later) the establishment of **health visitors** was raised from 75 to 85, the number actually employed increased only from 58 at the end of 1953 to 61 at the close of 1954.

CO-OPERATION WITH GENERAL PRACTITIONERS

(10) **Co-operation of Health Visitors and General Practitioners.**—A sustained and not unsuccessful effort was made to improve liaison between health visitors and general practitioners. Persons interested in the subject may care to have their attention directed to a detailed memorandum which was sent to all general practitioners and which is reprinted in the section of the report dealing with Health Visiting.

TEACHING OF MEDICAL AND NURSING STUDENTS.

(11) **Teaching of medical undergraduates and student nurses.**—Adequate co-operation of preventive and curative officers is impossible unless each knows a little about the work of the other. (The health medical officers and the health visitors have a knowledge of curative work, since, before specialising, they had to train as doctors and nurses, respectively, and subsequently worked in hospital

as resident medical officers and staff nurses or ward sisters.) For some years, each medical student has—in addition to receiving formal lectures on public health—spent the mornings of a fortnight visiting homes under the direction of a health visitor. In 1954, parallel teaching was begun in respect of student nurses at the combined training school of Aberdeen Royal Infirmary and Woodend Hospital: each nurse receives in her final year six lectures from members of the staff of the Health and Welfare Department and then has an opportunity of visiting clinics and of visiting (with a health visitor) families in their own homes.

(12) **Extension and improvement of health visitor training school.**—Although the Health Visitor Training School had done excellent work (achieving, indeed, in 1952-53 and 1953-54, the remarkable double triumph each year of gaining a hundred per cent. pass of its students and of taking top place in the national examination), the Corporation became aware in 1953 that a single-tutor school was an anachronism, and that, if post-qualification training of qualified health visitors was also to be undertaken, the appointment of a second tutor was imperative. A second qualified health visitor tutor was therefore appointed early in 1954, and the presence of two tutors rendered possible such advances as the mental health course and the home safety campaign, as well as the introduction of study days on individual subjects.

A start was made in 1954 at modernising the furniture of the training school and providing the beginnings of a reference library. During the year a project for extending the accommodation of the school (by provision of a second lecture room and a students' study) was under consideration, but was deferred pending consideration of the availability of other, more satisfactory premises.

(13) **Increase in domestic help service.**—During 1954, the number of domestic helps employed was raised to the maximum figure authorised by the Corporation and, at the end of the year, the authorised establishment was increased to 109.

(14) Until 1953 the child guidance clinic was hampered by the fact that no medical officer was available for the physical assessment of children referred there. From just before the beginning of 1954, a medical officer has devoted one session each week to examinations at the clinic.

(15) Fifteen other developments in the **School Health Service** are summarised at the beginning of the section of the report dealing with the School Health Service.

(16) In February, 1954, a fourth **residential hostel for old people** was opened at 30, Albyn Place. Work was in progress at the end of the year for the adaptation of premises at Newhills and Polmuir Road.

(17) **A register of old people living alone** and of old couples living alone was started just before the beginning of 1954. By the end of the year, over 800 names were on the register, and there was general agreement that its existence

made it easier to assess the needs of old people in general, as well as facilitating the assistance of individuals.

VISITS TO OLD PEOPLE.

(18) One of the great advantages of a combined Health and Welfare Department is that one officer, the health visitor, can undertake both medico-social and welfare duties in the home. During the year, the number of **old people being regularly visited by health visitors** increased from 300 to over 700. The health visitor's advice on diet, clothing, proper balance of rest and exercise, and development of leisure interests can do much to maintain the health of elderly citizens; and where an old person is beginning to need assistance (*e.g.*, a home help, or chiropody) the health visitor can assess the need and initiate action.

It is interesting to note that less than one elderly person out of every hundred visited expressed himself as not desiring the visits—a fact that is incidentally a high tribute to the tact and ability of the health visitors.

STUDY-DAY ON ELDERLY.

(19) Neither the older departmental medical officers in their D.P.H. training nor the older health visitors in their health visiting training received as much instruction on the health care of the elderly as is given to persons now being trained. To try to minimise this handicap, a study week-end was arranged for health visitors and a study session was held for medical officers. More information is given in the section of the report dealing with training.

CHIROPODY.

(20) The **chiropody service** for elderly citizens developed considerably during the year and the **mobile meals service** was expanded to the limits of its present capacity.

CRIPPLES.

(21) 1954 was the first year of a service for **physically handicapped persons** (apart from the blind and deaf). 336 persons have so far registered and have been visited by the specialist health visitor or the social worker. In many cases it has been possible to give useful advice. An occupation centre has appeared as an outstanding need in many cases, and the provision of such a centre has been approved in principle by the Corporation. At the end of the year, however, no suitable building had yet been found.

MISCEL- LANEOUS.

(22) At the end of the year, developments were beginning to take place in the **dental service**, an **orthoptist** was in process of being appointed, discussions were taking place with officers of the Regional Hospital Board about the provision of **physiotherapy** (*e.g.*, relaxation exercises at the ante-natal clinics), and consideration was being given to the establishment of a clinic for the **early diagnosis of deafness**.

STAFF INCREASES IN RECENT YEARS.

Developments such as have taken place in recent years would manifestly have been impossible without some increases of staff. During 1951-54 certain increases were sanctioned from time to time.

In the latter part of 1954, the Medical Officer of Health submitted a report containing long-term staffing proposals for all sections of the Health and Welfare

Department, with the exception of the Dental Section and a possible Health Education Section. It is worthy of record that all the proposals were not merely approved by the Corporation on 6th December, 1954, but *were approved unanimously*.

For the sake of clarity, it may be desirable to indicate the alterations of staffing. The following summary excludes the staffs of old people's homes (since the Corporation could not discharge its statutory duty to provide homes without staffing them).

(A) Staff increases before December, 1954.

(1) **Medical Officers.**—In 1951, the medical establishment was 13 full-time (Medical Officer of Health, Deputy, and 11 Departmental Medical Officers) and 2 part-time Medical Officers. In 1953, two posts as Departmental Medical Officers were upgraded to secure recruits of adequate calibre, but at 5th December, 1954, the establishment still comprised 13 full-time and 2 part-time officers.

(2) **Dental Officers.**—In 1951, the establishment of dental officers was 7 (including the Chief Dental Officer). This is less than the customary figure of 1 dentist for every 3,000-4,000 school children, but the establishment has not yet been altered.

(3) **Superintendent Nursing Officers and Health Visitor Tutors.**—In 1951, the establishment totalled 3. At the beginning of 1954, it was increased to 4 by the inclusion of a second Health Visitor Tutor. This extension made possible the introduction of the post-qualification courses which have already been hailed as the most significant development for many years.

(4) **Health Education Officers.**—There are still none on the establishment.

(5) **Health Visitors.**—In 1951, the establishment was 65. In 1953, it was increased to 75. This increase will be further discussed under heading (C).

(6) **Midwives.**—In 1951, the establishment was 8. During 1954, it was increased to 9. The main reason for this increase was the Governmental policy of seeking to encourage a greater number of women to have their babies at home.

(7) **Sanitary Inspectors.**—In 1953, to secure suitable candidates, the post of Fish Inspector was upgraded; and in 1954, the establishment was increased by 1 assistant sanitary inspector. (No account is here taken of an alteration in the grading of all sanitary inspectors to bring their salaries into line with those paid by other authorities.)

(8) **Ancillary Staff.**—In 1952, Aberdeen, which had previously been the only Scottish city not providing audiometric services for children, appointed an audiometrician. At the end of 1953, a part-time social worker was added to the establishment to facilitate the development of services for cripples. A part-time statistician was also appointed. In 1954, an assistant nurse was appointed for tuberculosis work, one-third of the salary being recoverable from the Board of Management for the Aberdeen Special Hospitals, and in the same year an orthopodist was added to the establishment.

(9) **Dental Attendants.**—In 1953, the number of dental attendants was increased from 2 to 4.

(10) **Staff of Nurseries.**—In 1953, a teacher was added to the staff of Linksfield Nursery and a handyman was appointed at Pitfodels Nursery. In 1954, a cook was appointed at Deeside Nursery (following its extension) and 2 laundry maids were appointed to Pitfodels Nursery.

(11) **Clerical Staff.**—In 1953, one male clerk was added to the establishment and in 1954, one junior clerkess was added. (Owing to the transfer of responsibility for Welfare Foods from the Ministry of Food to the Corporation, two clerical officers also passed from the establishment of the Ministry to that of the Corporation).

(12) **Cost of these Increases.**—The gross annual costs can be summarised thus (the health gain and the financial saving being considered later):—

	At minimum of scale.	At maximum of scale.
Upgrading of 2 medical officers	£450	£550
Assistant H.V. tutor and upgrading of other tutor	610	735
Ten additional health visitors	4,200	5,450
One additional midwife	420	545
One sanitary inspector and upgrading of fish inspector	540	590
Audiometrician, social worker, statistician, orthoptist, and assistant nurse	1,565	2,055
Dental attendants	460	600
Nursery staff	1,510	1,730
Clerical staff	405	650
	<hr/> £10,160	<hr/> £12,905

Since practically all of these increases (except those of sanitary inspectors) qualify for grant (50 per cent. in the case of the National Health Service and 60 per cent. in the case of the School Health Service), the **net annual cost** to the City is approximately £5,400 if all officers are at the minimum of their scales and £6,600 if all officers are at the maximum of their scales.

(B) Long-term Policy—Increases in December, 1954.

The staff increases unanimously approved by the Corporation on 6th December, 1954, may be thus summarised:—

(1) **Medical Officers.**—Increase by 1 departmental medical officer as from June, 1955. This is the only numerical increase in the medical establishment for a number of years.

(2) **Dental Officers.**—No change.

(3) **Superintendent Nursing Officers and Health Visitor Tutors.**—No change.

(4) **Health Education Officers.**—Still none.

(5) **Health Visitors.**—Increase of 10 over a series of years (see later).

(6) **Health Visitor Supervising Nurseries.**—Slight upgrading.

(7) **Midwives.**—Increase of one.

(8) **Sanitary Inspectors.**—Appointment of one additional apprentice and one additional district inspector.

(9) **Meat Detention Officers.**—Increase of two, consequent on ending of meat rationing.

(10) **Dental Attendants.**—Increase of two.

(11) **Clerks.**—Increase of one.

(12) **Home Helps.**—Increase of twenty.

(13) **Cost of these Increases.**—The gross annual costs of these future increases, when they become operative, may be summed up as follows:—

	At minimum of scale.	At maximum of scale.
Medical officer	£950	£1,300
Health visitor supervising nurseries (upgrading) . .	20	35
Health visitors	4,200	5,450
Midwife	420	545
Sanitary inspectors	755	925
Meat detention officers	1,100	1,160
Dental attendants	480	625
Clerk	140	470
Home helps	5,120	5,120
	<hr/> £13,185 <hr/>	<hr/> £15,630 <hr/>

Since all of these appointments qualify for annual grant (at 50 per cent. or 60 per cent.), except those of sanitary inspectors and detention officers, and since part of the expenditure on home helps is recoverable, the net cost to the Corporation will be approximately £6,800 if all officers are at the minimum of their scales and £8,200 if all officers are at their maximum.

(It may be noted that the gross totals in (A) and (B), when added, tally exactly with the totals contained in a statement prepared by the City Chamberlain just after the end of 1954, provided that there are deducted from the Chamberlain's figures (1) the cost of staff of old people's homes, (2) the cost of the clerks taken over from the Ministry of Food for welfare foods, and (3) the cost of upgrading the entire sanitary staff to bring salaries into line with those in other areas.)

(C) The Increase in Health Visitors.

An increase of ten health visitors is by far the biggest item in the piece-meal staff enlargements outlined under (A), and another increase of ten is the biggest item in the long-term programme indicated under (B).

It may therefore be desirable to discuss briefly the health visiting establishment, which was 23 as recently as 1947, and is now 85 (with 61 actually employed at the end of 1954).

PRE-1948
REQUIREMENT
OF HEALTH
VISITORS.

Before 1948, when the work of health visitors was largely restricted to expectant and nursing mothers and pre-school children (with school children added where the visitors also acted as school nurses), the generally recommended complement was one health visitor for every 500 pre-school children. For example, the official report on **Infant Mortality in Scotland** (H.M. Stationery Office, 1943) advised that a health visitor with six weekly half-days free for home visiting should be required to supervise not more than 500 children under 5 years; a standard text-book (J. L. Burn's **Recent Advances in Public Health**, 1947) advocated one health visitor per hundred annual births where the health visitor was employed full-time on maternity and child welfare, and a smaller case-load if she was required also to undertake school nursing or tuberculosis work; and a statistical analysis published in the **Health Bulletin of the Department of Health for Scotland** (January, 1949) showed by a study of Scottish towns for 1941-43 and 1944-46 that "if other factors remain unaltered, each successive extension of the health visiting staff (at least up to a level of 1 per 100 births) can be expected to result in a reduction of infant deaths."

EXTENDED
DUTIES.

The pre-1948 standard of one health visitor per 100 annual births may be expressed as one per 6,000 total population. On that standard, Aberdeen required about 30 health visitors before 1948.

Since 1948, the duties of health visitors have become enormously extended. They are now concerned with the health-care of the whole family, with the prevention of both physical and mental diseases, and with advice on matters ranging from the weaning of the baby and the behaviour difficulties of the toddler to the problems of family budgetting and the maintenance of morale in the elderly.

SUGGESTED
REQUIREMENTS.

Various attempts have been made to define numerical standards. For instance, the Deputy Chief Medical Officer of the Department of Health for Scotland has advocated a minimum establishment of one health visitor for every 2,500 population, and by printing this in the official **Health Bulletin** (July, 1951), the Department of Health for Scotland has presumably given its approval to this standard. On this basis, a town of 185,000 inhabitants would require 74 health visitors at least. Again, Professor Fraser Brockington has assessed the need at approximately the same level as for general practitioners, *i.e.*, about one for every 2,200 population. On this basis, Aberdeen would need about 84 health visitors.

The difficult housing circumstances of the City and the remarkably high proportion of its inhabitants in the lowest of the Registrar-General's social classes make it important that Aberdeen should not have less than the standard complement of health visitors. Moreover, since the amalgamation of the Health Department and the Welfare Department, many duties formerly discharged by welfare officers are undertaken by health visitors. Hence an establishment of 85 health visitors is likely to be rather below the ultimate requirement of the City.

It should perhaps be mentioned at this point that the Corporation some years ago obtained the sanction of the Secretary of State for Scotland for an ultimate establishment of up to 100 health visitors. My own view, for what it is worth, is

that the full hundred will not be required within the measurable future, and that the Corporation's duties under existing legislation could be adequately discharged by about 90 health visitors.

However, it will be a number of years before Aberdeen manages to fill the 85 places on its present establishment. There is a shortage of health visitors—nationally—far more grave than is the shortage of members of any other profession. Three reasons for this tremendous shortage may be outlined as a matter of interest:

(1) Nursing as a whole has fallen behind other professions in remuneration; during the war, for instance, nursing and school teaching were roughly equated, but in recent years nursing salaries have failed to keep pace with advances in other professions or with increases in the cost of living.

(2) In recent years the old relativities between health visitors and hospital ward sisters have been altered, so that a ward sister who takes additional qualifications in midwifery and health visiting actually receives as a health visitor a salary slightly less than she was given as a ward sister; health visiting is probably the only profession in which full-time study for obligatory additional qualifications is rewarded by a reduction in pay.

(3) Health visiting suffers badly from lack of promotion avenues: at present there are senior posts (as superintendents, tutors, &c.) available for only about 4 per cent. of health visitors; and for these top-ranking posts—for which yet another year of full-time study for the administrator's or tutor's certificate is usually a prerequisite—the salaries offered are less than those paid to the rank-and-file members of many other professions.

Tribute to the importance of the health visitor's work and to her high value to the community has been paid by so many individuals and organisations that phrases like "the spearhead of the social service" and "the health counsellor of the family" are in danger of becoming hackneyed; but until tribute is reinforced on a national level by a more realistic attitude towards remuneration, the number of women taking the three-fold qualification of trained nurse, midwife, and health visitor is likely to be insufficient to meet the community's needs.

(D) Health Gains from Staff Increases.

As mentioned above, staff increases sanctioned in 1951-54 are likely to cost the City between £5,400 and £6,600 a year when all the posts are filled, and the further increases unanimously approved on 6th December, 1954, will ultimately cost the City another £6,800 to £8,200.

In view, however, of the proved statistical correlations between infant mortality and inadequacy of health visitor staffing, and in view of the obvious influence of the staff of a health department on the health of the people served by that department, it would be hard to believe that the staff increases of 1952-53 merely happened to be followed by a year (1953) in which the vital statistics were the best ever recorded for the City; and it would need a good deal of credulity to believe that the further increases of 1953-54 were unrelated to the great improvement in vital statistics for 1954.

(E) Financial Gain from Staff Increases.

It would be a profound mistake to imagine that the appointment of disease-preventing officers costs the community money in salaries without any corresponding financial gain. Three examples will perhaps illustrate the point.

(1) A considerable amount of attention is now being devoted by the disease-preventing officers in Aberdeen to the health-care of the elderly—to trying to ensure that old people are enabled to live happily and healthily in their own homes for as long as possible, instead of having to be admitted to hospitals or residential institutions.

MONEY SAVED ON HOSTELS.

Even if one ignores hospitals (as a charge on the tax-payer, not the rate-payer), the saving on residential hostels is startling. The official report on **The Ageing Population** assessed hostel needs at $2\frac{1}{2}$ places per 100 old people, *i.e.*, roughly 500 places for Aberdeen. Because of the vigorous policy of maintaining the health of old people, the Aberdeen requirement of hostel places has been assessed at approximately 350 places (including places in "voluntary" hostels). In other words, the City's requirements are being planned on the assumption that improved health-care of the elderly is reducing by 150 places the total hostel accommodation needed.

To keep 150 old people in residential homes would cost slightly more than £30,000 a year, from which might be deducted approximately £10,000 that the hostel inmates would contribute towards their maintenance. Hence, development of services for the health-care of the aged is saving the City £20,000 a year—a sum considerably greater than the cost to the City of all the staff increases sanctioned.

SAVING ON TREATMENT OF ACCIDENTS.

(2) Since the prevention of accidents is still in its early stage, it is perhaps best not to give an estimated figure but to make a theoretical calculation. If a health visitor in the course of a whole year's work prevents only four serious accidents, the victims of which would otherwise have had to spend seven weeks each in hospital at a weekly cost of £15, the saving is £420 (or about the whole of the health visitor's initial annual salary), to say nothing of the saving of human suffering.

PREVENTION OF BROKEN HOMES.

(3) To quote from a distinguished health visitor speaking at a conference on health education, "If a health visitor by her advice to one borderline family containing four children enables that family to remain within the bounds of normal behaviour and saves these children from having to be taken into care, then the financial gain to the community during the whole childhood of these four is greater than the health visitor's total salary." In this connection, it will be remembered that the Secretary of State for Scotland, in a recent circular about the prevention of broken homes, advised local health authorities to consider the appointment of specialist health visitors or social workers, and the possible expansion of their health visiting service and their home help service as a matter of long-term economy.

AWARDS, PUBLICATIONS, &c.

An outstanding event of the year was the award by the World Health Organisation of a Senior Travelling Fellowship to Miss D. J. Lamont, Principal Health Visitor Tutor. Although W.H.O. Senior Fellowships have in the past been held by a few prominent medical officers of health, it is believed that this is the first time in this country that the award has been made to a public health nurse. In addition to reflecting great credit on the recipient, the award may be interpreted as indicating the rising prestige of the health visiting profession.

Dr Sarah Lorimer, Departmental Medical Officer, had the honour of sharing an Elliston Scholarship, tenable at London University, and Miss Margaret Nairn, health visitor, gained a British Commonwealth and Empire Travelling Scholarship.

During the year the Health and Welfare Department secured—jointly with the Health Department of Edinburgh—a research grant from the Advisory Committee for Medical Research, to pay in full for the cost of a fairly long term investigation into combined immunisation against diphtheria, whooping cough, and tetanus. The grant includes the cost of the salaries of a half-time research medical officer, a full-time research health visitor, and a half-time clerk.

In 1954 the Health Visitor Training School repeated the dual triumph that it had achieved in the previous year—gaining a 100 per cent. pass of candidates in the national examination for the health visitor's certificate and taking top place in that examination.

In the course of the year Dr. Dorothy Younie, Senior Assistant Medical Officer, was elected President of the Scottish Child Health Group of the Society of Medical Officers of Health, Dr. MacQueen continued to hold the post of Honorary Secretary of the Scottish Branch of the Society of Medical Officers of Health and Mr. A. Hay, Chief Dental Officer, served as Honorary Secretary of the Public Health Group of the British Dental Association. The Medical Officer of Health also served on the Executive Council of the Scottish Association for Mental Health and on the Department of Health Consultative Committee of Medical Officers of Health, and was selected by the Aberdeen Division of the British Medical Association as one of its two representatives at the Annual Representative Meeting of that body. During the year the Medical Officer of Health was invited by the Secretary of State for Scotland to become a member of a special committee set up to make recommendations about building legislation.

At the end of the year, Dr. M. E. Mitchell, Deputy Medical Officer of Health, was appointed a Medical Officer of the Department of Health for Scotland. Her appointment continues an interesting linkage between the Health and Welfare Department of Aberdeen and the Central Department. It will be remembered that Dr. Kinloch, after being Medical Officer of Health for Aberdeen, went to the Department of Health for Scotland as its Chief Medical Officer, and that Dr. Gorrie (Dr. Mitchell's immediate predecessor) left Aberdeen to take up a post as a Medical Officer of the Ministry of Health in England, while the present Medical Officer of

Health reversed the process by coming to Aberdeen from a post similar to that which Dr. Mitchell has now obtained.

Some ADDRESSES GIVEN TO NATIONAL CONFERENCES by members of staff during the year were as follows:—(1) The Medical Officer of Health addressed the International Gerontological Congress at London on **The Medico-Social Care of the Elderly in the United Kingdom**; (2) The Medical Officer of Health gave a paper at the Annual Conference of the Association of Port and Air Port Medical Officers at Hull on **Some Aspects of the Health of Trawl Fishermen**; (3) The Medical Officer of Health addressed a joint meeting of the Scottish Branch of the Society of Medical Officers of Health and the Scottish Division of the Royal Medico-Psychological Association at Glasgow on **The Prevention of Diseases of Mental and Emotional Origin**; (4) Dr. M. E. Mitchell, Deputy Medical Officer of Health, addressed the Annual Meeting of the Scottish Midwives' Association at Aberdeen on 1st May, 1954, on **The Midwife and the Health Service**.

In addition, Miss D. J. Lamont, Principal Health Visitor Tutor, opened a discussion on **The Health Visitor To-day** at the Annual Meeting of the Scottish Health Visitors' Association at Ayr; Miss M. K. Coull, Health Visitor, opened a discussion on **Tuberculosis** at the Annual Conference of the Royal Sanitary Association of Scotland at Dundee; and the Medical Officer of Health opened a discussion on prevention of mental diseases at the Annual Conference organised by the Scottish Association for Mental Health at Peebles.

During the year the Medical Officer of Health took part in a television programme on the health of the elderly, and the shots included the Northfield Old People's Home (including Danny, the dog!) and a Health Visitor, Miss Henderson, visiting an old lady in her home. Subsequently, Dr. MacQueen and Miss Lamont took part in a radio programme on the elderly; and later in the year Dr. MacQueen, Dr. Barclay, and Miss Lamont were asked to take part in a special programme arranged in connection with Old People's Week.

Some articles published during the year include:—

1. *"The Care of the Family—The Role of the Health Visitor,"* by Miss D. J. Lamont ("Proceedings of the Royal Sanitary Association of Scotland").
2. *"A Critical Analysis of the Report on the Ageing Population,"* by Dr. MacQueen ("Transactions of the Scottish Association of Executive Councils").
3. *"A Mobile Clinic in a Scottish City,"* by Dr. Margaret Ormiston (Departmental Medical Officer) and Miss M. K. Coull (Health Visitor) ("The Nursing Times").
4. *"Mortality of Adult Males in a Scottish City,"* by Mrs. Doris Brebner (Statistician) and Dr. MacQueen ("The Medical Officer").
5. *"The Role of the Health Visitor in the Care of the Elderly,"* by Miss D. J. Lamont ("The Medical Officer").
6. *"Home Safety Campaign in a Scottish City,"* by Miss D. J. Lamont ("The Nursing Times").

7. "*The Rôle of the Public Health Department in the Prevention of Mental and Nervous Disease*," by Dr. MacQueen ("Public Health").
8. "*Artificial Feeding and Energy Requirements of Young Infants*," by Dr. F. E. Hytten (Midwifery Department, University of Aberdeen) and Dr. MacQueen ("The Lancet").

In addition to published articles, a great deal of research was conducted during the year but is still unfinished at the close of 1954. For example, a study is being made of the later effects of foetal anoxia, a detailed investigation of the needs of elderly people living alone is being undertaken, a somewhat similar study of physically handicapped persons is under way, the long-term detailed survey of the health of all children born in 1953 is continuing, and the research on combined immunisation (already mentioned) has started.

Research is, of course, the very life-blood of an active department. If a department is anything like adequately staffed and if the staff of that department are keen on their jobs, the undertaking of research is a foregone conclusion. Indeed, to a considerable extent, the alertness and energy of a health department can be estimated by the research that comes out of it.

TRIBUTE.

I have concluded the prefaces to my two previous annual reports by acknowledgments—to the members of the Health and Welfare Committee for their appreciation, help, and interest; to officers of other Corporation departments and of other branches of the National Health Service for generous co-operation; and to my colleagues in the Health and Welfare Department—medical officers, dental officers, health visitors, midwives, sanitary inspectors, welfare officers, nursery staffs, clerks, &c.—who, in general, despite staff shortages and, in many cases, very unsatisfactory accommodation, have seldom contented themselves with simply carrying out the work for which they were paid, but, of their own volition, have devoted much additional time and energy to a sustained effort to render the community more healthy. This year, in addition to expressing grateful thanks to all these, I should like to take the opportunity to pay tribute to the work of Dr. May D. Baird, whose ten-year period as Health Convener will end about the time when this report is printed.

When Dr. Baird took the helm in 1945, the total number of infant deaths in the previous three years was 558 (and in the last three years of peace, 1936-38, the number had been 648), whereas, in her final three years as Convener, the total number of infant deaths was 244: the difference represents an annual saving of 105 infant lives. In 1942-44 the total number of deaths in children aged 1-5 years was 109, while in 1952-54 it was 40: the difference represents an annual saving of 23 child lives. In 1942-44 the total number of still-births was 255, while in 1952-54 it was 183: this difference represents an annual saving of 24. Each of these paired comparisons is fair, or is even slightly biassed in favour of the earlier period, because the total number of live births in 1942-44 (8.769) was slightly smaller than

the number in 1952-54 (9,330). Summation of these figures shows that, in 1942-44, the annual loss of lives in the pre-school period was 307, as compared with a figure of 155 in 1952-54, or a saving of 152 young lives annually.

In 1942-44, when diphtheria immunisation was in its early stages, there were 640 cases of diphtheria and 25 deaths (and in the last three years of peace, 1936-38, there had been 1,490 cases and 54 deaths); in 1952-54 there were 3 cases (all in 1952) and no deaths. In 1942-44 there were 227 deaths from pulmonary tuberculosis; in 1952-54 there were 81 deaths.

Perhaps the best single indication of the progress during Dr. Baird's convenership is the increase in the average age at death—

	1942.	1943.	1944.	1952.	1953.	1954.
Age in years . . .	57·9	57·5	58·4	64·6	65·1	66·3

Dr. Baird's convenership witnessed a great increase in the number of health visitors employed—from 23 (as recently as the end of 1947) to 61 (at the close of 1954)—and smaller increases in the numbers of medical officers and sanitary inspectors. Some of the major developments during the earlier part of her tenure of office included—the creation (in 1946) and gradual expansion of the home help service; the amalgamation (in 1948) of the Health Department and the Welfare Department; the establishing (in 1948) of the Health Visitor Training School and its subsequent progress; the taking over (in 1948) of the Gynæcological Advisory Clinic; some extension (in 1949) of the ante-natal and child welfare clinics that had been developed in the days of Dr. Mackintosh and Dr. Gorrie; and the opening (from 1950 onwards) of residential homes for old people. In more recent years there have been a mass of developments, including—the inauguration (in 1952) of the first chiropody service sponsored by any local health authority; the provision (in 1952) of the first mobile child welfare clinic used in a town; the creation (in 1952) of a night nursing service; the starting (in 1953) of immunisation of school children against tuberculosis; considerable developments (in 1953 and subsequently) in the school health service; the appointment of an audiometrician (in 1953) and of an orthoptist (just after the close of 1954); the setting up (in 1953) of a register of old people living alone; the conducting (from 1953 onwards) of a detailed health survey of all children born in 1953; the inauguration (in 1953) of a detailed study of the epidemiology of squint, and (in 1954) of a study of changing causes of mortality in the City; the development (in 1954) of a pioneer scheme for the welfare of physically handicapped persons; the beginning (in 1954) of in-service training for qualified health visitors; the obtaining (in 1954) of a research grant from the Advisory Council for Medical Research; and the organisation (in 1954) of the first full-scale Home Safety Campaign conducted in this country. More important, however, than any single concrete development in the ten years is the gradual transformation of outlook that occurred under Dr. Baird's inspiring leadership: when she became Convener, the main job of the Health Department was generally considered to be the prevention and treatment of infectious diseases; gradually, the conception has widened, until to-day it would be generally accepted

that the main tasks of the Health and Welfare Department include health education for the promotion of physical and mental health, study of the socio-economic, emotional, and environmental causes of diseases, and measures designed to reduce the prevalence of any variety of illness or disability.

It is no disrespect to the giants of the past to suggest that there was more progress during Dr. Baird's ten years as Convener than in any previous decade. Dr. Baird would undoubtedly be the first to state that a great deal remains to be done—more, indeed, than the sum total of all that has yet been achieved—but I am sure that all my colleagues would wish to join with me in this expression of gratitude to an inspiring leader who has captained the ship of health during ten eventful years.

I. A. G. MACQUEEN,

Medical Officer of Health.

HEALTH AND WELFARE DEPARTMENT,
WILLOWBANK HOUSE,
WILLOWBANK ROAD,
ABERDEEN, 4th April, 1955.

CITY OF ABERDEEN.

REPORT BY THE MEDICAL OFFICER OF HEALTH

For the year 1954.

1.—BACKGROUND DATA: DEMOGRAPHICAL, SOCIOLOGICAL, &c.

INTRODUCTION.

It is inevitable that any report on the health of a City during a year and on the work of its Health and Welfare Department in that year should consist largely of figures—death-rates and sickness rates, numbers or percentages of persons examined, statistics relating to defects found on examination, numbers of persons attending various clinics, numbers of visits paid by members of staff, and so forth. Such figures, however, cannot convey accurate information unless they are interpreted in the light of the social, economic, industrial, and climatic circumstances of the area to which they relate. A particular infant mortality rate might, for instance, be deemed high and regarded as an indication of unsatisfactory child welfare services in a wealthy, well-housed community, while the same rate in another town with much overcrowding, poverty, and unemployment might be deemed low and regarded as indicating that the services were functioning excellently.

Some of the more obvious points liable to influence the health of the City will already be known to every person who reads this report, *e.g.*, such points as that Aberdeen is a seaport with an extensive fishing fleet, that there is an airport just outside the City, that Aberdeen is a university town with a flourishing medical school, that the Corporation conduct a training course for health visitors, that the City is the natural commercial and industrial centre for a large agricultural hinterland, and that it has a bracing climate of the east-coast type. An attempt has been made below to set down certain additional basic demographical and socio-economic data for the City. For a more detailed survey of social conditions, &c., reference may be made to the Annual Report for 1952.

Points of special importance are the large proportion of men in the lowest socio-economic class (a proportion as high as in Glasgow and considerably higher than in other cities or in Scotland as a whole), the amount of unemployment (2,358 in the area of the Aberdeen Employment Exchange at 6th December, 1954), and the unfavourable housing circumstances (which, although in process of being overcome, still place Aberdeen at a disadvantage in relation to other cities).

GENERAL DATA.

Area of City.—After the extension of boundaries in 1952, the area (exclusive of inland water, tidal water, and foreshore) is 11,362 acres.

Population.—The 1951 census enumeration gave a total of 182,729, or, when corrected for normal residence, 183,247. The estimated population at the middle of 1953 was 185,232 and the estimated population at the middle of 1954 was 185,725.

Growth of the City.—The growth of the City (a factor of great importance when housing is considered) may be very roughly summarised as follows. For many centuries Aberdeen had a population of under 15,000. During the 18th century it increased to 27,000. In the thirty years, 1801-1831, the population doubled. In the next sixty years it doubled again. By 1911, it had risen to 163,891. During the twenty years, 1911-1931, there was little growth; the population in 1931 was 167,258, representing an average annual increase of 168 over the period. During the twenty years, 1931-1951, the average annual increase in the population was 798 and, in the years since the last census, the estimated annual growth is of about that figure.

Density of Population.—On the latest estimate the density is 16·3 persons per acre.

Number of Houses.—The number in 1954 was 54,057, an increase of 839 on the total in the previous year. The distribution of houses in the various Wards was as follows:—

Ward.	No. of Houses.	Ward.	No. of Houses.
No. 1—St. Clements . . .	4,666	No. 7—Rosemount . . .	3,664
No. 2—St. Nicholas . . .	5,470	No. 8—Rubislaw . . .	3,726
No. 3—St. Andrew . . .	4,552	No. 9—Holburn . . .	4,457
No. 4—St. Machar . . .	3,886	No. 10—Ruthrieston . . .	4,289
No. 5—Woodside . . .	4,632	No. 11—Ferryhill . . .	4,230
No. 6—Cairnery . . .	6,203	No. 12—Torry . . .	4,282

Average Number of Persons per House.—In the annual report for 1952, there were given the census figures for the four cities. The figure for Aberdeen was 3·48; and, based on the Registrar-General's estimate of the population (185,725) for the middle of 1954 and the City Assessor's return as to the number of houses in the City, the latest figure is 3·44.

Rateable Value (1953-54)—£2,150,489 10s.

Population—Age, Sex, and Marital Condition.—Detailed information was given in the Report for 1952, based on the census figures for 1951.

Proportion of Males to Females.—Figures for this were also given in the Report for 1952.

The Young and the Old.—The percentages of pre-school children, children of school age, and persons over 65 years in the four large cities in the last census year are given below—

	0-4 years.	5-14 years.	65+ years.
Aberdeen . . .	9·1 per cent.	14·1 per cent.	10·0 per cent.
Dundee . . .	9·0 " "	15·2 " "	10·4 " "
Edinburgh . . .	8·5 " "	13·3 " "	11·3 " "
Glasgow . . .	9·1 " "	15·7 " "	8·6 " "

The following table states the proportions of the population in various age-groups at census in 1911, 1921, 1931, and 1951 :—

	Under 1 year.	1 and under 5 yrs.	5 and under 15 yrs.	15 and under 25 yrs.	25 and under 45 yrs.	45 and under 65 yrs.	65 yrs. and upwards.
1911 . . .	2.23	9.03	22.13	19.13	26.84	15.31	5.33
1921 . . .	2.35	6.66	19.41	20.00	27.00	18.42	6.16
1931 . . .	1.75	6.81	17.22	18.65	28.51	19.81	7.25
1951 . . .	1.63	7.44	14.14	14.76	28.84	23.21	9.98

The estimated population of 185,725 in 1954 includes 3,143 under 1 year, 11,975 aged 1-4, 27,989 aged 5-14, 27,413 aged 15-24, 53,563 aged 25-44, 43,107 aged 45-64, and 18,535 aged 65 and over.

Marital Condition.—The outstanding change revealed by a comparison with twenty years ago is that a far higher proportion of men and women aged 20-30 years are married. There is also a slight increase in the proportion of widows (but not of widowers), and a rise in the number of divorced persons (to nearly 1 per 200 population).

Social Class Distribution of Adult Males.—A convenient socio-economic classification is that adopted by the Registrar-General who divides adult males according to occupation into five social classes. Class I includes such categories as ship-owners, company directors, architects, journalists, medical practitioners, solicitors, &c.; Class II contains farmers, farm managers, shop keepers, nurses, teachers, police inspectors, &c.; Class III, the biggest group, consists mainly of skilled artists and foremen—market gardeners and market gardening foremen, blacksmiths, shipwrights, plumbers, bus drivers, shorthand typists, postmen, &c.; Class IV is mainly semi-skilled workers—railway ticket collectors, paint sprayers, fishermen, bus conductors, barmen, hospital orderlies, &c.; and Class V includes unskilled workers—agricultural labourers, dock labourers, lift attendants, newspaper sellers, hawkers, &c. Exact figures based on the census enumeration have not been published, but the following percentages, calculated from the gross figures given in the Registrar-General's One per Cent. Sample Tables (H.M. Stationery Office, 1952), give, with a fairly small margin of error, comparative data for the four cities and for Scotland as a whole :—

PERCENTAGE OF EACH SOCIAL CLASS.						
	I.	II.	III.	IV.	V.	
Scotland . . .	2.96	13.21	50.92	18.21	14.71	
Aberdeen . . .	3.65	14.12	48.84	14.12	19.27	
Dundee . . .	2.03	9.98	51.62	18.45	17.93	
Edinburgh . . .	5.36	12.71	56.65	10.79	14.50	
Glasgow . . .	2.07	10.17	54.88	13.60	19.28	

Some important points that emerge from a study of the above table are :—

- (1) The percentage of persons in the lowest social class is practically identical in Aberdeen and Glasgow, being much higher than in any other city and very much higher than in Scotland as a whole. It may also be mentioned that the percentage of persons in Class V is appreciably higher in Aberdeen than in most English cities.

- (2) The proportion of persons in Classes IV and V taken together is greater in Aberdeen than in Glasgow.
- (3) Aberdeen has a smaller percentage of persons in Class III than any other Scottish city.
- (4) Aberdeen has a higher proportion of inhabitants in Class I than any city except Edinburgh.

Housing.—A detailed summary appeared in the Annual Report for 1952. Some salient points were—that more than one person in every eight was living under overcrowded circumstances (at more than two persons per room), and that Aberdeen was less favourably placed than the other Scottish cities in respect of the proportion of houses with such facilities as a piped water supply, a water-closet, a kitchen sink, and a cooking stove or range. Despite the vigorous housing programme of recent years, it will obviously be some time before Aberdeen can hope to draw level with the other cities.

Occupations.—As in previous years, it has not proved possible to provide an exact analysis of the gainfully employed members of the community in respect of occupation.

The Aberdeen Employment Exchange serves Aberdeen City and an adjacent county area (Bucksburn, Dyce, and Cults) with a population of approximately 15,000. According to the Ministry of Labour and National Service, the main occupations in the area served by this Exchange are—

Agriculture and Horticulture.	Food and Drink: Grain Milling.
Fishing.	Bread and Biscuit Making.
Stone Quarrying.	Meat Products.
Cast Concrete and Monumental Masonry.	Milk Products.
Chemicals and Allied Trades.	Fish Curing.
Engineering, Shipbuilding, and Electrical Goods.	Aerated Water Manufacture.
Motor Body Building and Motor Repairing (Garages)	Wooden Container and Basket Manufacture.
Metal Goods not elsewhere specified.	Paper and Printing.
Woollen and Worsted Manufacture.	Horn Comb and Plastics Moulding.
Flax Manufacturers.	Building and Contracting.
Net Making and Braiding.	Gas, Electricity, and Water Services.
Hosiery and Other Knitted Goods.	Transport and Communication Services.
Clothing : Tailoring.	Distribution Trades.
Dressmaking.	Insurance, Banking, and Finance.
Shirtmaking.	Public Administration and Defence.
Boot and Shoe Repairing.	Professional Services.
Sawmilling.	Entertainment and Sport.
Furniture and Upholstery.	Catering—Hotels, &c.
	Laundry and Dry Cleaning.
	Hairdressing.

Unemployment.—Unemployment during most of 1954 was not very extensive although rather more than in most recent years. At the latest date for which information is easily available (6th December, 1954), the numbers of unemployed persons in the area covered by the Aberdeen Employment Exchange were—

Men, 1,645; Boys, 23; Women, 666; Girls, 24; Total, 2,358.

Meteorological Data.

Temperature.—The lowest temperature registered during the year was 17°F (in the week ended 13th February). In the previous year, the lowest temperature recorded was 25°F on three different occasions.

The highest temperature registered was 73°F (during the weeks ended 24th July and 26th August). The highest temperature recorded during the previous year was 77°F.

The diagram on page 6 gives the maximum and minimum temperatures during each week of the year.

Rainfall.—The total rainfall during the year (at Craibstone, just outside the City) was 35·12 inches, as compared with 28·86 inches in 1953. The distribution of rainfall in the different months is shown in diagrammatic form.

Sunshine.—1954 was not a very favourable year for sun. The average daily hours of sunshine during each month are shown in the diagram.

Wind.—The average wind velocity during each month is shown in the following tables:—

WIND VELOCITIES AND DIRECTIONS.

From three-hourly readings at the Meteorological Office of Dyce Airport, the number of gusts of varying velocities in each month was as follows:—

Month.	Number of Gusts at various speeds (in miles per hour).				
	Over 38. m.p.h.	25-38. m.p.h.	12-24. m.p.h.	1-11. m.p.h.	Calm.
January	1	28	115	79	25
February	0	15	78	90	41
March	0	12	76	126	34
April	0	16	60	114	50
May	0	5	93	123	27
June	0	7	59	147	27
July	0	2	68	147	31
August	0	2	62	196	48
September	1	13	90	100	36
October	0	5	72	132	39
November	0	25	94	88	33
December	3	28	99	92	26

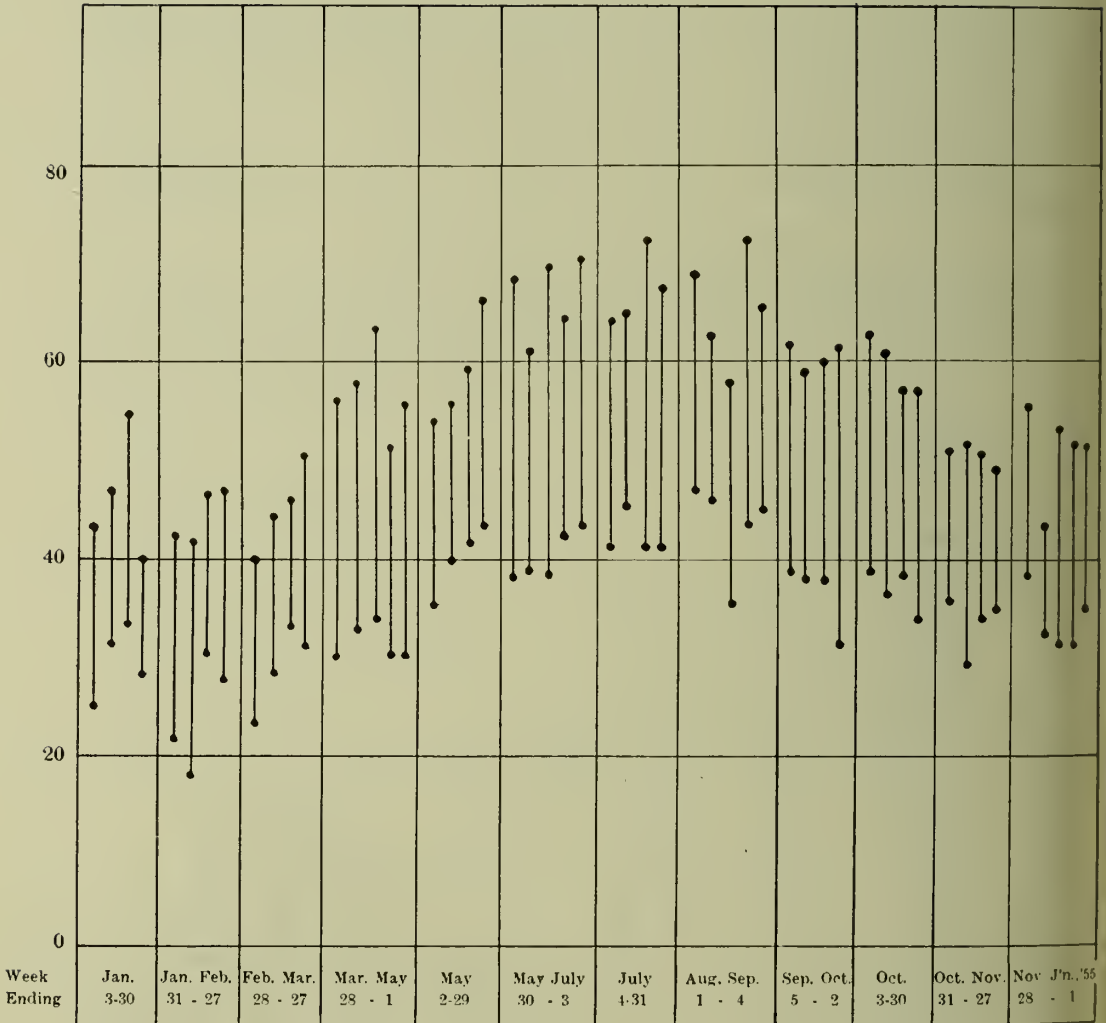
The directions of the various gusts in each month were—

Month.	Number of Gusts from							
	North.	N-E.	East.	S-E.	South.	S-W.	West.	N-W.
January	19	2	7	24	51	13	60	47
February	7	3	10	43	51	27	16	26
March	15	5	4	36	92	21	29	12
April	20	7	18	11	53	12	32	37
May	67	16	20	40	32	0	7	39
June	33	4	21	24	53	21	23	34
July	31	1	3	9	56	12	46	59
August	58	8	14	21	32	18	14	35
September	6	0	1	13	68	30	55	31
October	12	2	5	14	50	45	47	34
November	3	0	6	26	70	26	45	31
December	6	3	10	4	45	36	76	42

CITY OF ABERDEEN.

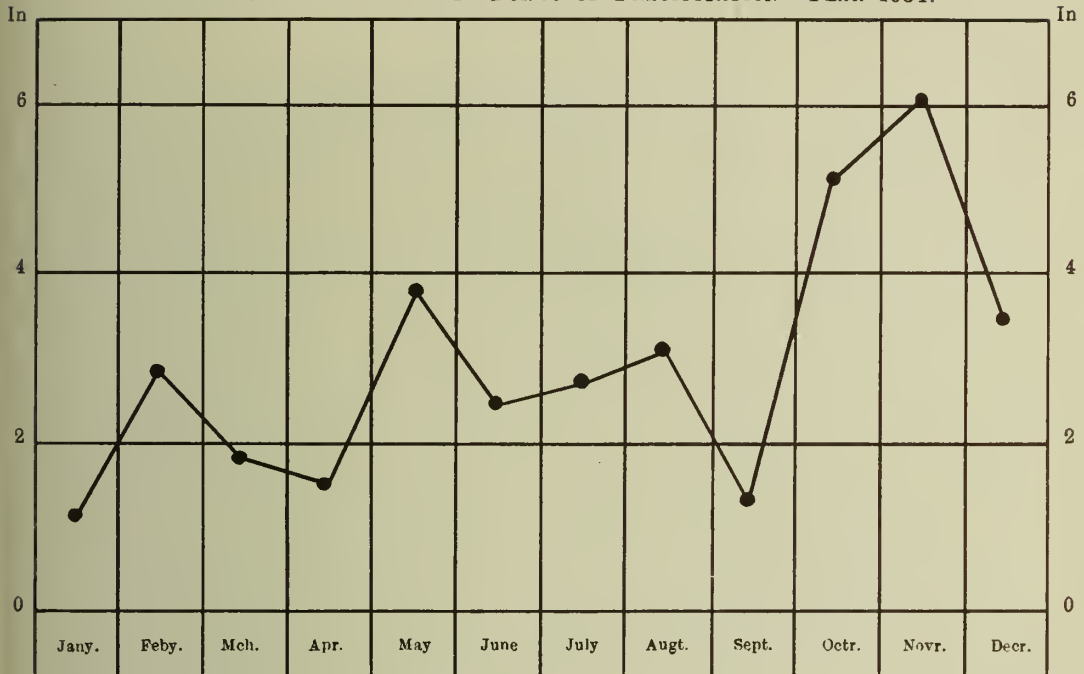
TEMPERATURE OF ATMOSPHERE—WEEKLY MAXIMA AND MINIMA
°FAHR.

YEAR, 1954.

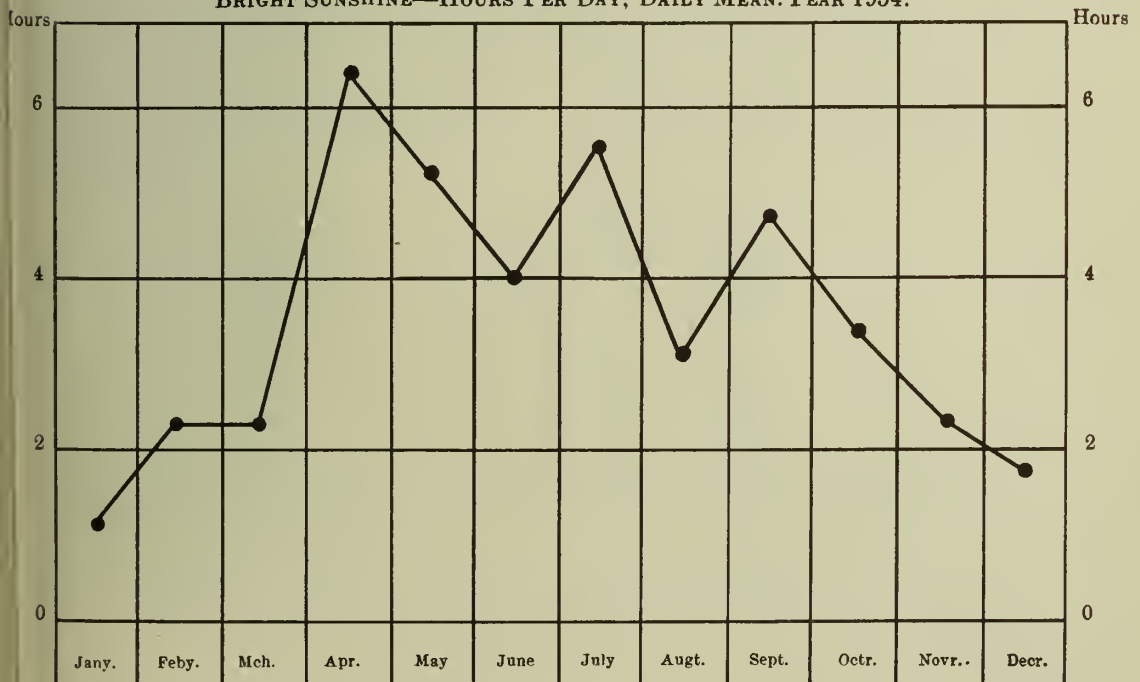


CITY OF ABERDEEN.

TOTAL RAINFALL AND OTHER FORMS OF PRECIPITATION—YEAR 1954.



BRIGHT SUNSHINE—HOURS PER DAY, DAILY MEAN. YEAR 1954.



2.—VITAL STATISTICS OF 1954.

Some of the main features of the year may be briefly summarised—(1) Although the infant death-rate (22 per thousand live births) still compares unfavourably with the rates of some English cities and with the rates in Sweden and New Zealand, it is far below any figure previously recorded for Aberdeen. (2) There are only eight deaths in children aged 1-5 years, the lowest number in any previous year being 13. (3) The total loss of young lives (*i.e.*, the aggregation of still-births and deaths of infants, pre-school children, and school children) constitutes a third new low record. (4) The average age at death (66·3 years) is higher than ever before. (5) The tuberculosis death-rate (0·12 per thousand population) is considerably lower than the previous record low figure of 0·16 for 1953. (6) The reduction in the fraction of the general death-rate attributable to deaths from violence may be evidence of the success of the home safety campaign. (7) The birth-rate is a little higher and the general death-rate is a little lower than in any recent years. (8) The illegitimate birth-rate has fallen from the record low figure of 4·5 per cent. of all live-births in 1953 to 4·3 per cent. (9) The still-birth-rate and the maternal mortality rate have each only once been lower than in 1954.

The table on page 8 gives the number of births, still-births, and infant deaths during the year and in a number of previous years.

LIVE BIRTHS.

The total number of live births during 1954, corrected for "transfers," was 3,228, of whom 3,088 were legitimate and 140 illegitimate. The live birth-rate was 17·4 per 1,000 of population, a good deal higher than the figures for 1952 and 1953.

The following table shows the rates for Aberdeen and for all Scotland over a period of eight years. The trend in Aberdeen is very similar to that in the country as a whole.

Year.	Live Birth Rate per 1,000 Population.	
	Aberdeen.	Scotland.
1954	17·4	18·0
1953	16·6	17·8
1952	16·5	17·7
1951	16·5	17·7
1950	17·2	17·9
1949	17·5	18·5
1948	19·1	19·4
1947	22·0	22·0

In 1954, the birth-rates in the other principal cities were:—Glasgow, 19·4; Edinburgh, 15·5; and Dundee, 18·1.

The **natural increase** for the year (*i.e.*, the excess of births over deaths) was 1,172, as compared with 986 in 1953, 877 in 1952, and 847 in 1951,

BIRTHS, STILL-BIRTHS, INFANT MORTALITY.
YEARS 1944-1954.

YEAR.	No. of Live Births.	Live Births per 1,000 of Population.	Illegitimate Births, per cent. of Live Births.	No. of Still Births.	Still Births per 1,000 Total Births, incl. Still Births.	No. of Deaths of Infants under 1 Year.	No. of Deaths of Infants under 4 Weeks.	Neo-natal Deaths per cent. of Total Infant Deaths.	Death-rates from all Causes per 1,000 Live Births.				Death-rates among Infants under 1 Year of Age from Various Causes per 1,000 Live Births										
									Rates.			Tuberculosis.	Common Zymotic Diseases.	* Pneumonia and Bronchitis.	Diarrhea and Enteritis.	Congenital Malformations.	Injury at Birth.	Ateleclasis.	Immaturity.	Accidents.	Other causes.		
									Total under one Year.	(Under 4 Weeks (Neo-natal Rate)).	4 Weeks and under Six Months.											Six Months and under One Year.	
1954 .	3228	17.4	4.3	64	19	70	50	71	21.7	15.5	4.3	1.9	0	0	5	0	3	1	7	2	0.3	4	
1953 .	3077	16.6	4.5	62	20	84	57	69	27	19	6	2	0	0	6	0.3	4	2	8	3	1	3	
1952 .	3025	16.5	5.7	57	18	90	54	60	30	18	8	4	0	0	6	0	5	1	8	2	1	7	
1951 .	3028	16.5	5.4	66	21	82	55	67	27	18	6	3	0	1	6	0.3	4	2	5	6	2	1	
1950 .	3226	17.2	5.3	74	22	92	54	54	29	17	10	2	0	0.3	6	0.3	5	2	4	5	2	5	
1949 .	3306	17.5	5.7	63	19	100	54	54	30	16	12	2	0.3	1	7	3	5	1	5	4	1	3	
1948 .	3598	19.1	5.9	98	27	121	72	60	34	20	10	4	0	1	5	5	4	4	5	6	2	2	
1947 .	4124	22.0	5.9	107	25	263	108	41	64	26	28	10	0.2	2	13	22	4	2	8	5	2	6	
1946 .	3762	20.4	7.0	115	30	158	92	58	42	24	16	2	0.5	0.3	6	9	5	3	7	7	1	3	
1945 .	2830	15.5	10.0	71	24	152	76	50	54	27	21	6	0.4	2	8	11	5	6	4	11	0.4	6	
1944 .	2989	16.5	9.2	68	22	169	83	49	57	28	23	6	0.3	1	14	7	7	5	6	8	2	7	

* Including under 4 Weeks.

Sex-ratio of births.—Of the total 3,228 live births, 1,689 were males and 1,539 were females, giving a ratio of 1·10 (*i.e.*, 110 males per 100 females). The sex-ratio in Aberdeen has been consistently high in recent years; it was 1·07 in 1953, 1·09 in 1952, and 1·11 in 1951.

Illegitimate Live-births.—In 1954, there were 140 illegitimate births, representing a rate of 4·3 per cent. of the total live births. For all Scotland, the rate was 4·5 per cent. For many years, illegitimacy has been a grave social problem in Aberdeen, and the illegitimate birth-rate has been very high. Last year it was recorded with pleasure that the rate, besides being the lowest ever recorded in Aberdeen, had fallen by more than a fifth in a single year, and was at last below the average for Scotland. This year a further fall is recorded.

STILL-BIRTHS.

There were 64 still-births in 1954, as compared with 62 in 1953, 57 in 1952, 66 in 1951, and 74 in 1950. The still-birth rates for these years were:—1954, 19; 1953, 20; 1952, 18; 1951, 21; and 1950, 22.

The fact that the still-birth rate has not yet fallen below the record low figure established in 1952 need cause no despondency. All such figures are subject to minor fluctuations from year to year, and in every recent year the Aberdeen still-birth rate has been gratifyingly low. Indeed, it may be mentioned that officers of the Health and Welfare Department anticipated—in view of rises in the cost of living—a still-birth rate in 1954 appreciably higher than that actually recorded. As was mentioned in last year's report, credit for the continued low rate is due to all concerned with ante-natal and obstetrical care, and a very important factor is the co-operation at the ante-natal clinics (attended by about nine-tenths of expectant mothers) of clinical experts from the staff of the Regional Hospital Board and medico-social experts from the medical and health visiting staff of the Corporation.

The following table gives the rates for Scotland and for the principal cities:—

	Still-birth Rate per 1,000 Total Births.			
	1954.	1953.	1952.	1951.
All Scotland	25	25	26	27
Glasgow	29	27	27	28
Edinburgh	21	22	27	27
Dundee	28	25	24	25
Aberdeen	19	20	18	21

Thus, Aberdeen continues to have the lowest still-birth rate, a fact which is the more remarkable in view of the high percentage of the population in the lowest social classes.

Of the 64 still-births (corrected for “transfers”) (36 males and 28 females), 63 occurred in institutions and 1 at home.

Still-births, 1939-54.—Analysis of still-births from 1939 shows that, while the rate from all causes, except deformity, fell fairly steadily till 1945, the only causes which have subsequently continued to diminish have been birth trauma and deaths of

mature babies from unexplained causes. The deaths from prematurity and antepartum hæmorrhage have slightly increased since 1945. The main explanation of the fall in the fraction of the still-birth rate ascribed to birth trauma is that practically all primigravidae are now confined in hospital and there is a high incidence of Cæsarean section in difficult labour: the rise in the fraction of the rate between 1946 and 1948 was due to the large increase in the birth-rate, which resulted in many women having their first baby at home since they could not gain admission to hospital. Many were "elderly," having put off child-bearing during the war years, and in such cases labour is often difficult and the still-birth rate high, so that they should be confined in hospital.

The rise in deaths from prematurity and antepartum hæmorrhage since 1945 might be explained by a slight deterioration in standards of nutrition and diet since then. The still-birth rate in the City of Aberdeen has been round about 19 for the last three years, and it seems unlikely there will be any marked change in the next few years.

Analysis of Still-births.—Detailed information is available for all the still-births, and from this it was ascertained that 25 (or 39 per cent.) were primipara pregnancies, 15 (or 23 per cent.) were second pregnancies, and the remaining 24 (or 38 per cent.) were subsequent pregnancies. The following summary shows the ages of the mothers:—

	TOTAL	AGE OF MOTHER					
		Under 20 years	20-24	25-29	30-34	35-39	40+
1st Pregnancy	25	5	12	5	3	—	—
2nd Pregnancy	15	—	5	6	3	1	—
Subsequent Pregnancies	24	—	5	5	6	6	2
TOTAL	64	5	24	16	12	7	2

The causes of the still-births were as follows:—

Chronic disease in mother—

Anæmia	2
Hypertension	2
Mitral stenosis	1
Diabetes	1
—	6

Diseases and conditions of pregnancy and childbirth—

Antepartum hæmorrhage	13
Toxæmia of pregnancy	10
—	23
Trauma	2
Trauma—Cord conditions	3
—	5

Congenital malformation of fœtus	9
Diseases of fœtus and ill-defined causes—	
Rhesus factor	2
Prematurity—Cause unknown	9
Full-term—Cause unknown	10
	— 21
	—
	64
	=

INFANT DEATHS.

In 1953, there were 84 deaths of babies under the age of one year, giving a rate of 27 per thousand live-births, and no lower rate had ever been recorded in Aberdeen. In 1954, there were 70 baby deaths, giving an infant mortality rate of 22 per thousand live-births. A glance at the table on page 8 will reveal that, as recently as seven years ago (1947), the number of baby deaths was 263 and the infant mortality rate was 64.

Satisfactory though the present figure may appear, it must be remembered that it still compares unfavourably with some English cities and even more unfavourably with the rates obtaining in such countries as Sweden and New Zealand. In considering the Aberdeen infant mortality rate, however, three points must be kept in mind—

- (1) As indicated in the section on background data, Aberdeen and Glasgow have a higher proportion of persons in the lowest social class than have other cities or Scotland as a whole, and Aberdeen has a larger proportion in the two lowest social classes than has Glasgow.
- (2) As indicated in the paragraph on housing, Aberdeen—despite its vigorous housing programme—compares unfavourably with other cities.
- (3) While considerable extensions in the health visiting staff were sanctioned during the year, the actual increase in staff employed during 1954 was comparatively slight.

In view of these points, an infant mortality rate of 22 can be regarded as a real triumph, although it is hoped that improvement in the housing situation on the one hand and gradual expansion of the health visiting service on the other may contribute to a further reduction of infant deaths in the next few years.

Comparison with National Figures and with other Cities.—The average rates for all England and Wales and all Scotland, as well as for the four principal cities, are given below for the last three years—

	Infant Death Rates.		
	1954	1953.	1952.
England and Wales	26	27	28
Scotland	31	31	35
Glasgow	35	36	41
Edinburgh	25	24	29
Dundee	33	32	31
Aberdeen	22	27	30

The accompanying coloured chart shows the infant mortality rate in Scottish cities and in Scotland as a whole since 1856, and a table (inserted after the subsection on mortality in pre-school children) shows the actual number of deaths in Aberdeen in various years.

Causes of Infant Deaths.—Table I, at the end of this section of the Report, gives details of the causes of death and the age at which each child died. An analysis of the infant deaths that have occurred during the last three years reveals that the death-rates from various causes were as follows:—

	Infant Death Rates, per 1,000 Live Births.		
	1954.	1953.	1952.
Congenital malformations	3	4	5
Atelectasis	7	8	8
Birth injuries	1	2	1·3
Diarrhoea and enteritis	0	0·3	0
Pneumonia and bronchitis	5	6	6
Common infections	0	0	0
Tuberculosis	0	0	0
Suffocation and other accidents	0·3	1	1
Immaturity	2	3	2·3
Other causes	4	3	6
Total	22	27	30
	==	==	==

Neo-Natal Deaths.—In 1954, the number of deaths of infants under the age of four weeks was 50, as compared with 57 in 1953. The neo-natal death-rate of 15 per thousand live-births is a new low record. The neo-natal death-rates for Scotland and for the four principal cities in 1952-1954 are as follows:—

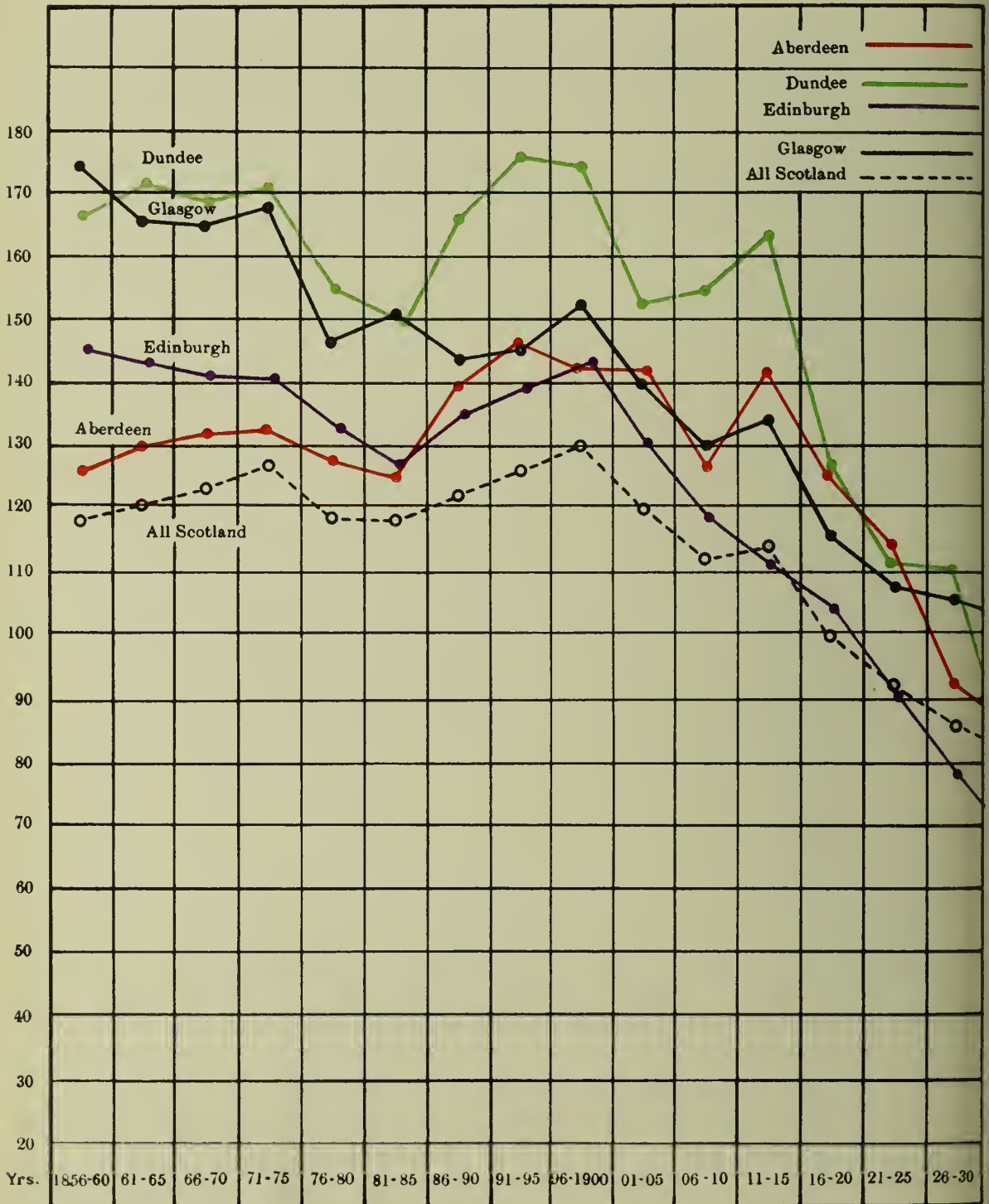
	Neo-natal Death Rates.		
	1954.	1953.	1952.
Scotland	21	19	22
Glasgow	21	22	24
Edinburgh	19	16	17
Dundee	23	20	20
Aberdeen	15	19	18

Post-Natal Deaths.—In 1954, there were only 20 deaths of infants aged four weeks to 12 months, as compared with 27 in 1953 and 36 in 1952. The post neo-natal death-rate of 6 per 1,000 live-births is a low record for the City and compares very favourably with a rate of 10 for Scotland as a whole. It should, however, in the future be possible to reduce the rate still further.

MORTALITY IN PRE-SCHOOL PERIOD (1·5 years).

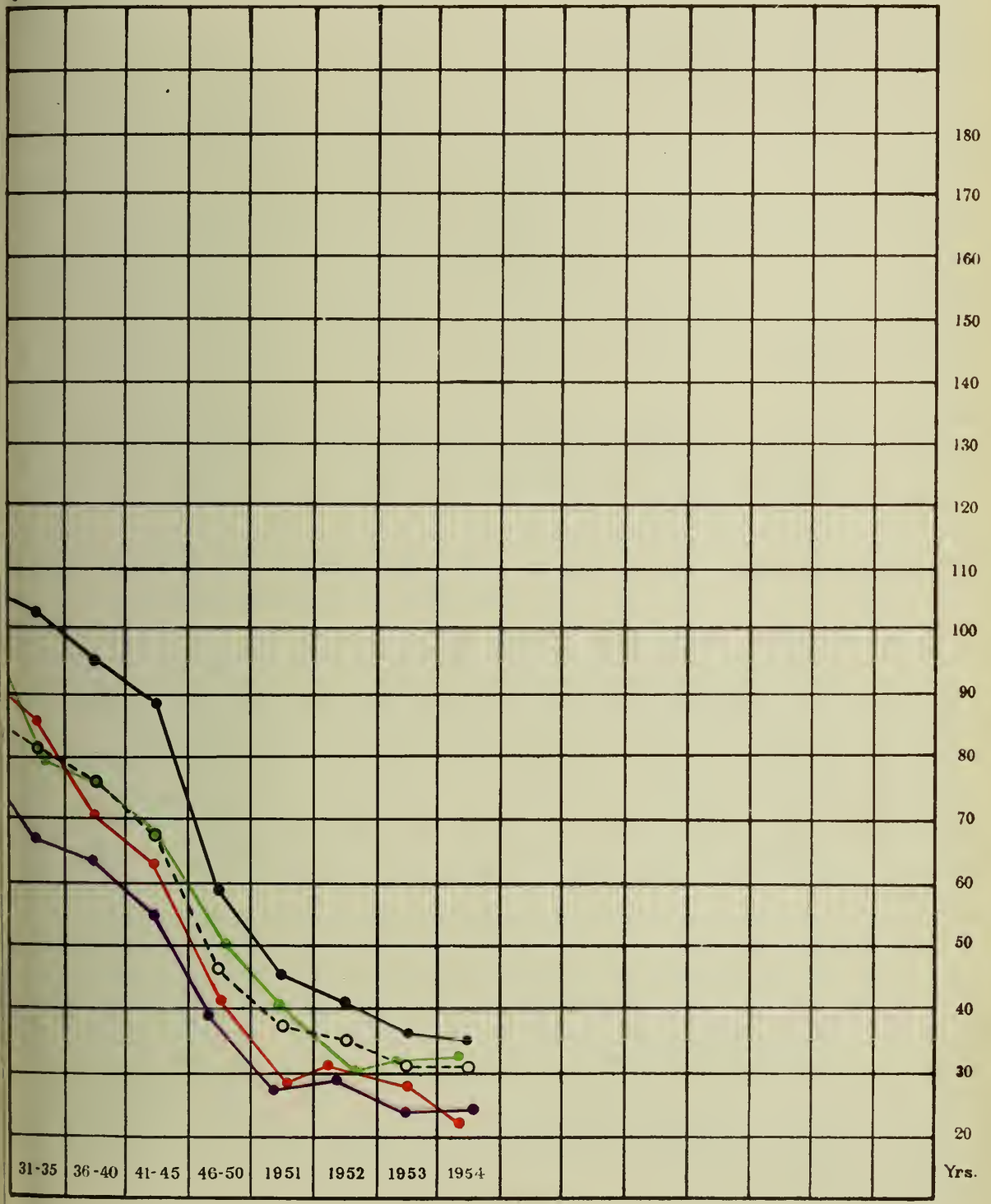
During 1954, 8 children aged 1·5 years died, the lowest number yet recorded in any year. Details are—

Deaths under 1 year



QUINQUENNIAL AVERAGES. 1856-1950.

per 1,000 Births.



Age-group.	Number of Deaths in			
	1954.	1953.	1952.	1951.
1 - 2 years	2	8	6	4
2 - 3 years	3	4	3	4
3 - 4 years	2	4	2	3
4 - 5 years	1	3	2	5
	—	—	—	—
	8	19	13	16
	==	==	==	==

Of the 8 deaths in 1954, 1 was due to an accident on roadway; 3 to tuberculous meningitis; 1 to congenital malformations; 1 to meningococcal septicaemia; and 2 to miscellaneous causes. There were no deaths from home accidents.

In the previous year, there were five fatal accidents at this age-period.

The decline of accidents which in most recent years have been the commonest cause of death at the age-period 1-5 years is noteworthy.

DECLINE IN INFANT AND PRE-SCHOOL DEATHS.

In 1904 (when deaths were first allocated by the Registrar-General to the place in which the deceased had lived, instead of simply the place where they died), 733 infants under one year and 367 children aged 1-5 years died in Aberdeen, a total of exactly 1,100 young deaths. In 1954 there were 70 deaths of infants under 1 year and 8 of children aged 1-5 years, a total of 78.

Some of the main factors in the decline are—

(1) The gradual development of the disease-preventing and health-promoting services of the Health Department (re-named, since 1948, the Health and Welfare Department). In this connection, it is worthwhile to note that, in the burghs of Scotland at two different periods investigated, a highly significant correlation has been found to exist between the infant death-rate and the degree of inadequacy of health visitor staffing.

(2) Increase of health education (which is, of course, a very important facet of the work of a Health Department).

(3) The eradication of various infectious diseases by specific immunisation, contact tracing, isolation of patients, sanitary and hygienic measures, &c.

(4) Improvements in the standard of living, and in particular better nutrition. This factor may be taken as including both the changes in living standards consequent on increases in the earnings of the lowest paid sections of the community and the changes produced by advice to housewives on wise spending of the money available.

(5) Better housing. We perhaps tend to be so aware of the problem of overcrowding and unsatisfactory housing to-day that we are in danger of forgetting how infinitely worse were circumstances in the past.

(6) Better ante-natal and obstetrical care. This factor may be taken as including both the clinical and the preventive and medico-social aspects.

(7) Development of medical knowledge and provision of better treatment facilities for sick children.

(8) Establishment of the family planning clinic, spread of knowledge of contraceptive techniques, and social recognition of the desirability of the spaced family.

(9) Measures for the reduction of illegitimacy, and measures for the better care of the unmarried mother and her child.

The following table gives the infant death-rate in various years and the actual number of children aged 0-1 year and 1-5 years dying in these years.

Year.	Infant Mortality Rate.	Actual Deaths under 1 year.	Actual Deaths. 1-5 years.	Actual Deaths. 0-5 years.	Year.	Infant Mortality Rate.	Actual Deaths under 1 year.	Actual Deaths. 1-5 years.	Actual Deaths. 0-5 years.
1905	138	678	233	911	1930	80	265	85	350
1906	127	599	273	872	1931	90	292	69	361
1907	125	561	256	817	1932	93	296	98	394
1908	129	577	260	837	1933	79	238	94	332
1909	149	671	277	948	1934	77	235	80	315
1910	111	478	167	645	1935	91	286	118	404
1911	139	563	285	848	1936	70	214	77	291
1912	127	530	232	762	1937	72	219	62	281
1913	152	591	400	991	1938	71	215	78	293
1914	121	487	259	746	1939	59	177	38	215
1915	173	654	405	1,059	1940	86	241	70	311
1916	112	398	182	580	1941	77	224	39	263
1917	139	399	270	669	1942	67	194	39	233
1918	143	390	267	657	1943	68	195	34	229
1919	118	399	159	558	1944	57	169	36	205
1920	121	591	144	735	1945	54	152	34	186
1921	108	460	80	540	1946	42	158	25	183
1922	133	527	284	811	1947	64	263	19	282
1923	104	391	156	547	1948	34	121	14	135
1924	122	421	207	628	1949	30	100	23	123
1925	109	368	143	511	1950	29	92	19	111
1926	96	328	105	433	1951	27	82	16	98
1927	105	334	101	435	1952	30	90	13	103
1928	94	313	142	455	1953	27	84	19	103
1929	95	297	113	410	1954	22	70	8	78

The gross numbers are, of course, a poorer guide than the rates; in a year in which the birth-rate was high (*e.g.*, 1954 or the four consecutive years 1946-1949) the number of baby deaths would—other things being equal—normally be larger than in a year in which the birth-rate was low (*e.g.*, 1951 or 1952). Even the rates are, of course, subject to slight variation from statistical chance; for instance, it would be unreasonable to argue that the health and health services of the City were worse in 1937 (when the infant death-rate was 72) than in the previous year (when it was 70); but the general trend is clear enough.

MORTALITY IN SCHOOL PERIOD.

In 1954, there were 11 deaths of children of school age (as compared with 15 in the previous year). The causes were as follows:—drowning, 1; pneumonia, 4;

lymphadenoma, 1; leukaemia, 2; and 3 to miscellaneous causes. It is interesting to notice the absence of infectious diseases (the commonest cause of death in the past) and of accidents (which, in recent years, have tended to become the most numerous cause).

MARRIAGES.

During 1954, there were 1,894 marriages within the City. This is equivalent to a rate of 10·2 per thousand of the population. The rates in previous years were:—1953, 10·4; 1952, 10·5; 1951, 10·0; 1950, 9·9; and 1949, 9·7.

MATERNAL MORTALITY.

According to the Registrar-General's Preliminary Return for 1954, in all Scotland, 70 women died from causes peculiar to pregnancy and childbirth (as compared with 86 in 1953, 92 in 1952, and 99 in 1951), and deaths from puerperal sepsis numbered 15 (as against 20 in 1953, 22 in 1952, and 27 in 1951).

In Aberdeen, during 1954, there were 2 deaths from causes related to pregnancy and childbirth. In neither case was the death ascribed to puerperal sepsis. In 1953, there were seven deaths, including two in which the death was ascribed to puerperal sepsis, and in 1952 there were two deaths, due to causes other than puerperal sepsis. When deaths are down to small numbers, it is probably wiser to study the average figures for a series of years, as in the last line of the table below, which gives a comparison between Aberdeen and all Scotland in recent years:—

Rates per 1,000 live and still births

Year	Maternal Mortality		Puerperal Sepsis		Other Puerperal Conditions	
	Scotland	Aberdeen	Scotland	Aberdeen	Scotland	Aberdeen
1954	0·7	0·6	0·16	0·0	0·58	0·6
1953	0·9	2·2	0·2	0·6	0·7	1·6
1952	1·0	0·6	0·2	0·0	0·8	0·6
1951	1·1	1·3	0·3	0·3	0·8	1·0
1950	1·1	0·3	0·2	0·0	0·9	0·3
1949	1·3	0·9	0·24	0·3	1·01	0·6
Average 1949-1953	1·08	1·06	0·2	0·2	0·8	0·8

DEATHS.

The total number of deaths, the death-rate per 1,000 of population, and the average age at death for each of the years 1949-1954 are given in the following table:—

Year.	Number.	Rate per 1,000 of Population.		Average age at Death.
1954	2,056	...	11.1	66.3
1953	2,091	...	11.3	65.2
1952	2,148	...	11.7	64.6
1951	2,181	...	11.9	65.7
1950	2,266	...	12.1	64.9
1949	2,213	...	11.7	64.1
Mean of 1949-1953	2,180	...	11.7	64.9

For all Scotland, the death-rate in 1954 was 12.0, in 1953, 11.5, and in 1952, 12.0.

Age at Death.—The average age at death of all persons dying during 1954 was 66.3 years, as compared with 65.1 in 1953 and 64.6 in 1952. 1954 is the first year in which the average age at death has reached 66. It is interesting to note that, in the quinquennium 1891-95, the average age at death was 32.9 years, and that, as recently as ten years ago (1944) it was 58.4 years. Of the 2,056 deaths, 193 (or 9 per cent.) occurred in persons below the age of 45 years. This compares with a figure of 233 (or 11 per cent.) in 1953 and 267 (or 12 per cent.) in 1952. An analysis of these 193 young deaths by cause is as follows:—

Malformations and diseases of early infancy	63
Diseases of the circulatory system	26
Malignant disease	24
Pneumonia and bronchitis	20
Violence	19
Diseases of nervous system	13
Tuberculosis	10
Genito-urinary	6
Diseases of digestive system	4
Puerperium	2
Miscellaneous	4
Infectious diseases—Meningococcal Septicæmia	1
Acute Poliomyelitis	1

The reduction in the number of deaths from violence in this age-group (from 40 in 1953 to 19) is particularly noteworthy. It is, however, well worth while to look carefully at this list of deaths in the first 45 years in order to ask the question—in respect of the main causes, are we as yet doing all that we can to prevent them?

505 (or 25 per cent.) of all deaths occurred in the age-period 45-64 years, so that a total of 698 fatalities (or 34 per cent.) occurred before the age of 65 years. 562 deaths (or 27 per cent.) occurred in the age-period 65-74 years, and 796 (or 39 per cent.) occurred at ages of 75 and over. (In 1953, 38 per cent. and, in 1952, 37 per cent. of all deaths were of persons aged 75 and upwards.)

Causes of Death.—Table II at the end of this section gives full details of the causes of death operating in each age-group, and the diagram below shows some of the more important causes. It is interesting to note that 75 per cent. of all deaths fall under three headings—diseases of circulatory system, diseases of nervous system, and malignant diseases. The comparable figure for 1953 was 72 per cent.

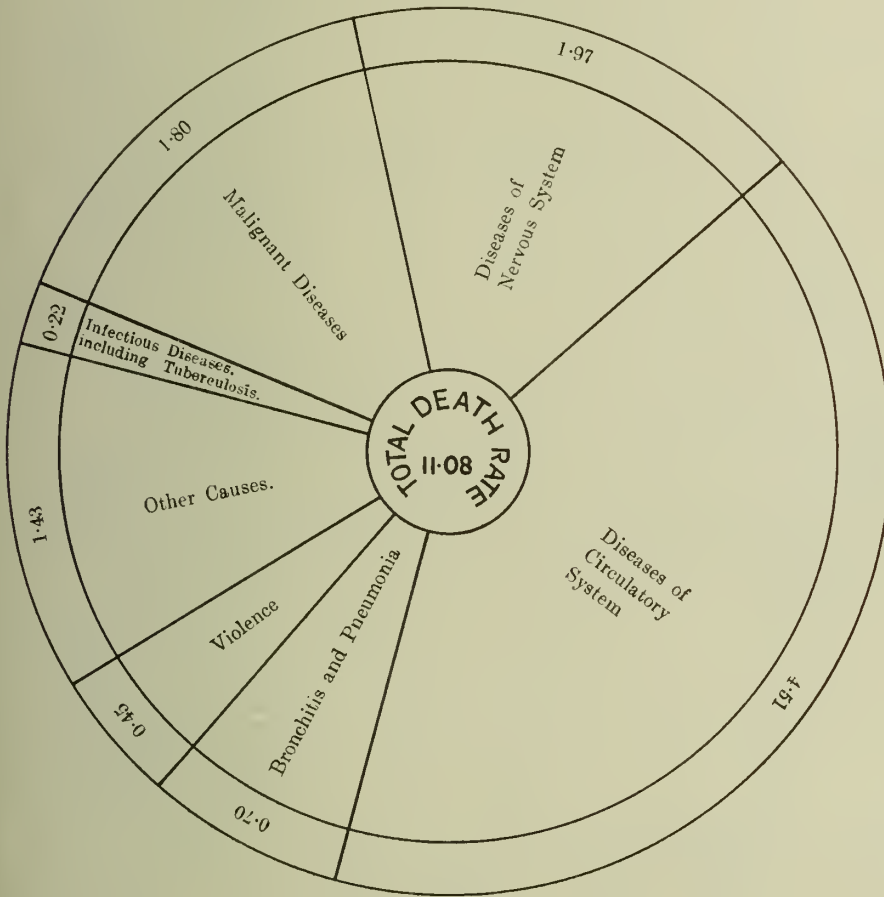


Table III gives for a number of successive years the death-rates at all ages from selected causes, and Table IV gives, in summary form, details of population, marriages, births, deaths, average age at death, and infant deaths for a number of years and for quinquennial averages.

To conclude this section (apart from the tables), the diagrams illustrate the trends of mortality from various causes in recent years.

TABLE I.—CAUSES OF DEATH AMONG CHILDREN UNDER FIVE YEARS OF AGE.
YEAR 1954.

CAUSES OF DEATH	AGE																			
	FIRST YEAR										SECOND TO FIFTH YEARS									
	First Four Weeks				First Three Months			The Four Quarters			SECONDS TO FIFTH YEARS									
	0-1	-2	-3	-4	* 0-1	-2	-3	*	I	II	III	IV	Total	-2	-3	-4	-5	Total	0-1	1-5
Tuberculosis { Respiratory	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	0-2	0-4
Diphtheria { Other Forms	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1
Dysentery . . . . .	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	0-2
Measles . . . . .	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Meningococcal Infections	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	0-4	...
Polomyelitis, Acute . . .	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	0-2	1
Scarlet Fever . . . . .	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Whooping Cough . . . .	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Other Infective and Parasitic Diseases	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Pneumonia . . . . .	...	...	...	...	...	5	2	...	7	2	2	1	11	...	...	...	...	...	1	2
Bronchitis . . . . .	...	...	...	...	...	...	...	...	...	...	...	...	1	1	...	...	...	...	...	...
Diarrhoea and Enteritis	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1	1
Other Digestive Diseases	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Congenital Malformations	2	1	1	1	...	...	...	...	5	2	...	...	...	...	...	...	...	...	...	...
Injury at Birth	3	...	...	...	...	...	...	...	3	...	...	...	...	...	...	...	...	...	3	0-4
Post-natal Asphyxia and Atelectasis	22	1	...	...	...	...	...	...	23	...	...	...	23	...	...	...	...	...	...	...
Pneumonia of New Born	3	...	...	...	...	...	...	...	6	...	...	...	6	...	...	...	...	...	...	...
Other Infections of New Born	2	...	...	...	...	...	...	...	2	...	...	...	2	...	...	...	...	...	...	...
Other Diseases peculiar to Early Infancy	3	...	...	...	...	...	...	...	4	...	...	...	4	...	...	...	...	...	...	...
Immaturity	6	...	...	...	...	...	...	...	6	...	...	...	6	...	...	...	...	...	4	...
Accidents or other Violence	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Other Causes	1	...	...	...	...	...	...	...	1	2	...	...	3	...	...	...	...	...	...	...
ALL CAUSES	42	2	4	2	51	5	2	58	6	6	4	2	70	2	3	2	1	8	90	18
Average for preceding 5 years, 1949-1953	48	3	1	2	55	7	7	69	13	5	3	90	7	5	3	3	18	...	...	...

* This column includes all deaths in preceding columns.

TABLE II.—ABERDEEN.—MORTALITY AT VARIOUS AGE PERIODS FROM VARIOUS CAUSES.

(Corrected for transferred deaths.)

AGE.	All Causes.		Infectious and Parasitic Diseases (excl. Tuberculosis).		Tuberculous Diseases.		Malignant Diseases.		Dis. of Nervous Syst. and Sense Organs.		Dis. of Circulatory System.		Respiratory Diseases.		Dis. of Digest. System (incl. Diarrhea and Enteritis).		Dis. of Genito-Urinary System.		Dis. of Pregnancy and Child-birth.		Violence.	Miscellaneous.	
			Principal Epidemic.	Other Infections.	Respiratory.	Other Tuberculous.			Cereb. Hem., etc.	Other Nervous.			Pneumonia.		Other Respiratory.				Puerperal Sepsis.	Other Diseases.			
													Bronchitis.	Dis. of Respiratory.	Dis. of Digest. System (incl. Diarrhea and Enteritis).	Dis. of Genito-Urinary System.							Dis. of Pregnancy and Child-birth.
Under 1 year .	70	—	1	—	—	—	—	—	—	3	—	—	11	1	—	1	—	—	—	—	1	—	
1-4 years .	8	1	—	—	—	3	—	—	—	2	—	—	—	—	—	—	—	—	—	—	1	1	
5-14 " .	11	—	—	—	—	—	3	—	—	1	—	—	4	—	—	—	—	—	—	—	1	2	
15-24 " .	14	—	1	1	1	—	1	1	1	1	1	1	1	—	—	—	—	—	1	—	5	1	
25-34 " .	26	—	—	3	—	—	5	—	2	1	3	—	—	—	—	—	2	—	—	—	7	3	
35-44 " .	64	—	—	3	—	—	15	—	2	—	22	1	2	1	3	4	—	—	1	—	4	6	
45-54 " .	183	1	2	6	—	—	64	13	3	3	51	3	3	2	9	9	—	—	—	—	11	6	
55-64 " .	322	—	5	4	—	—	74	38	3	3	131	6	6	12	4	12	4	—	—	—	14	15	
65-74 " .	562	—	2	2	1	—	99	116	4	4	243	13	20	2	20	12	—	—	—	4	17	7	
75+ " .	796	3	3	—	—	—	74	170	6	6	387	40	13	2	23	22	—	—	—	11	22	20	
All Ages	2056	5	14	19	4	335	342	24	838	79	51	11	68	53	—	2	52	83	15	2	83	61	

A.—NUMBER OF DEATHS—YEAR 1954.

AGE.	B.—DEATH-RATE PER 100,000.										
	3	7	10	2	180	184	13	451	43	27	
1954 .	1107	3	7	10	2	180	184	13	451	43	27

TABLE III.—ABERDEEN.—DEATHS AT ALL AGES FROM SELECTED CAUSES.
(per 100.000 of population).—Years 1856-1954.*

Year.	Smallpox.	Scarlet Fever.	Diphtheria and Croup.	Measles.	Whooping Cough.	Influenza.	Typhus Fever.	Typhoid and Paratyphoid Fever.	Tuberc. Dis.		Dis. of Digestive System (inc. Diarrhoea).	Cancer and other Malignant Diseases.	Bronchitis.	Pneumonia.	Diseases of the Circulatory System.
									Respiratory.	Other Tuberculosis.					
1954 . . .	0	0	0	0	0	2	0	0	10	2	37	180	27	43	451
1953 . . .	0	0	0	0	0	2	0	0	14	2	42	200	26	56	407
1952 . . .	0	0	0	0	0	3	0	0	20	2	40	228	31	34	434
1951 . . .	0	0	1	1	2	5	0	0	20	3	44	195	38	58	454
†1950 . . .	0	0	0	1	0	7	0	0	20	3	44	208	45	56	434
1949 . . .	0	0	0	1	0	5	0	0	32	3	44	182	43	58	414
Mean of 1949-53 .	0	0	0·2	1	0·4	4	0	0	21	3	43	203	37	52	429
1948 . . .	0	1	0	1	1	2	0	0	33	4	58	169	23	45	361
1947 . . .	0	0	0	2	3	1	0	1	35	6	90	177	38	59	402
1946 . . .	0	0	0	0	2	5	0	0	40	7	65	175	36	52	390
1945 . . .	0	0	6	2	2	4	0	0	43	9	64	177	35	44	383
1944 . . .	0	1	3	0	2	4	0	0	48	21	58	167	39	47	387
Mean of 1944-48 .	0	0·4	2	1	2	3	0	0·2	40	9	67	173	34	49	385
Mean of 1941-45 .	0	0·4	6	1	3	9	0	0·2	46	16	69	178	42	52	377
„ „ 1936-40 .	0	1	11	4	7	15	0	1	41	11	69	160	50	73	331
„ „ 1931-35 .	0	5	9	9	12	18	0	1	52	17	70	159	60	102	276
„ „ 1926-30 .	0·2	2	10	11	11	21	0	0·2	62	30	78	145	61	100	240
„ „ 1921-25 .	0	5	11	33	29	27	0	1	88	31	80	140	80	92	195
„ „ 1916-20 .	0	6	16	22	23	73	0	3	106	43	87	121	99	122	178
„ „ 1911-15 .	0·2	38	42	56	32	16	0	4	111	49	124	116	101	128	184
„ „ 1906-10 .	0	6	15	26	42	20	0	2	116	61	115	103	105	116	180
„ „ 1901-05 .	0·1	8	9	41	47	20	3	4	138	69	162	87	145	125	179
„ „ 1896-1900 .	0	23	18	35	53	29	0	9	167	70	210	87	172	109	167
„ „ 1891-95 .	0·4	21	22	63	52	56	1	10	181	72	190	81	210	100	156
„ „ 1886-90 .	1	14	10	80	66	9	1	15	184	67	202	68	216	100	175
„ „ 1881-85 .	0·2	13	15	36	67	1	6	13	204	74	185	69	251	82	159
„ „ 1876-80 .	1	35	30	28	66	2	19	29	223	101	194	61	286	72	146
„ „ 1871-75 .	48	68	30	53	68	5	20	35	243	107	214	56	281	60	136
„ „ 1866-70 .	4	71	35	50	62	8	62	49	298	130	259	59	238	70	122
„ „ 1861-65 .	36	93	49	51	62	12	176		274	128	280	57	220	59	122
„ „ 1856-60 .	40	118	54	70	69	12	109		322	179	203	56	182	58	111

*Corrected for transferred deaths in 1904 and subsequent years.

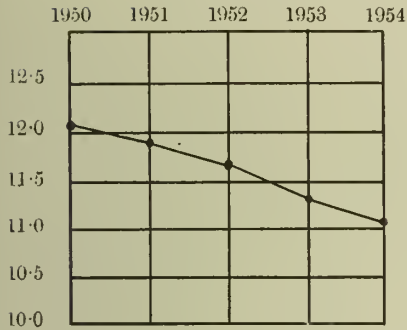
† From 1950 Causes of Death classified in accordance with Sixth Revision of International List of Causes of Death.

CITY OF ABERDEEN.

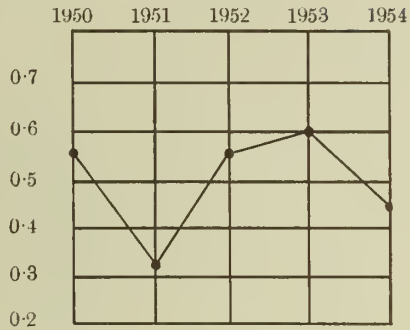
TRENDS OF MORTALITY, 1950-54.

DEATHS PER 1,000 POPULATION.

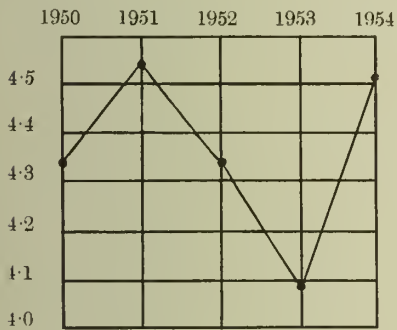
ALL CAUSES.



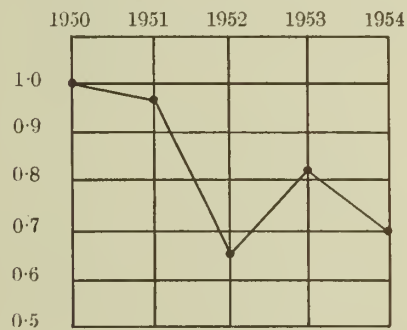
VIOLENCE.



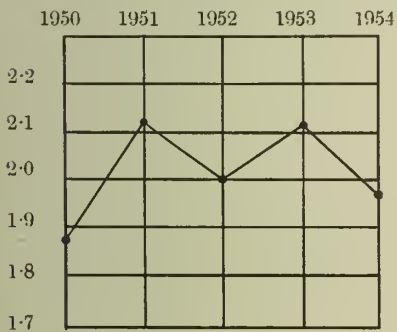
DISEASES OF CIRCULATORY SYSTEM.



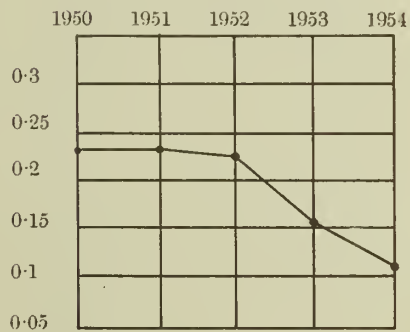
PNEUMONIA AND BRONCHITIS.



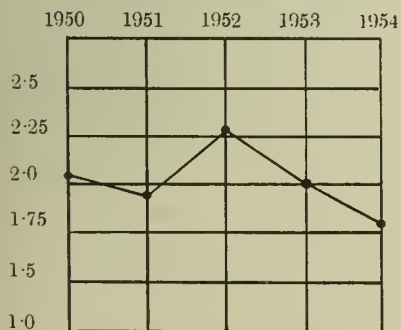
DISEASES OF NERVOUS SYSTEM.



ALL TUBERCULOSIS.



MALIGNANT DISEASES.



PRINCIPAL EPIDEMIC DISEASES.

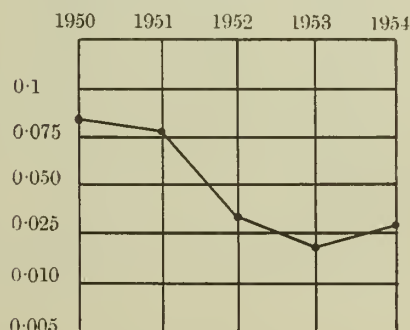


TABLE IV.—ABERDEEN.—MARRIAGE, BIRTH, AND DEATH RATE—1856 TO 1954.
Per 1,000 of population.

Year	Population†	Marriages		Live Births *			Deaths			Excess of Births over Deaths	Infantile Mortality Deaths of Infants under 1 year per 1,000 Births
		Number	Rate per 1,000 of Population	Number	Rate per 1,000 of Population	Illegit Births per 100 Total Births	Number	Rate per 1,000 of Population	Average Age at Death		
1954	185,725	1,894	10.2	3,228	17.4	4.3	2,056	11.1	66.3	1,172	22
1953	185,232	1,928	10.4	3,077	16.6	4.5	2,091	11.3	65.1	986	27
1952	183,626	1,929	10.5	3,025	16.5	5.7	2,148	11.7	64.6	877	30
1951	183,248	1,833	10.0	3,028	16.5	5.4	2,181	11.9	65.7	847	27
1950	187,961	1,853	9.9	3,226	17.2	5.3	2,266	12.1	64.9	960	29
1949	189,314	1,841	9.7	3,306	17.5	5.7	2,213	11.7	64.1	1,093	30
Mean of 1949-1953	185,876	1,877	10.1	3,132	16.9	5.3	2,180	11.7	64.9	952	29
1948	188,853	2,104	11.1	3,598	19.1	5.9	2,098	11.1	61.7	1,500	34
1947	187,751	2,091	11.1	4,124	22.0	5.9	2,242	11.9	57.3	1,882	64
1946	176,939	2,186	11.9	3,762	20.4	7.0	2,124	12.0	60.3	1,638	42
1945	163,108	2,286	12.5	2,830	15.5	10.0	2,084	12.8	59.6	746	54
1944	159,263	1,646	9.1	2,989	16.5	9.2	2,056	12.9	58.4	933	57
Mean of 1944-1948	†	2,063	11.1	3,461	18.7	7.6	2,121	12.1	59.5	1,340	50
1941-1945	162,687	1,944	10.8	2,901	16.1	8.8	2,172	13.4	57.9	729	65
1936-1940	†	1,962	11.0	2,973	16.7	6.2	2,243	12.7	55.4	730	72
1931-1935	171,959	1,590	9.2	3,133	18.2	7.1	2,284	13.3	52.1	849	86
1926-1930	165,956	1,510	9.1	3,263	19.7	8.2	2,207	13.3	49.1	1,056	94
1921-1925	161,622	1,582	9.8	3,763	23.3	8.2	2,303	14.3	44.4	1,460	115
1916-1920	161,568	1,754	10.9	3,479	21.5	10.6	2,439	15.1	41.7	1,040	127
1911-1915	164,324	1,489	9.1	3,959	24.1	10.2	2,752	16.8	38.1	1,207	143
1906-1910	163,620	1,360	8.3	4,505	27.5	9.7	2,512	15.4	37.6	1,993	128
1901-1905	158,082	1,428	9.0	4,872	30.8	8.5	2,763	17.5	34.9	2,109	143
1896-1900	145,740	1,356	9.3	4,636	31.8	8.3	2,644	18.1	33.3	1,992	144
1891-1895	131,627	1,099	8.4	4,114	31.3	9.8	2,539	19.3	32.9	1,575	147
1886-1890	117,587	911	7.8	3,827	32.5	10.4	2,370	20.2	...	1,457	140
1881-1885	108,959	848	7.8	3,712	34.1	10.6	2,159	19.8	...	1,553	126
1876-1880	100,419	788	7.9	3,480	34.7	10.9	2,100	20.9	...	1,380	129
1871-1875	91,941	705	7.7	3,169	34.5	12.1	2,063	22.4	...	1,106	133
1866-1870	84,234	684	8.1	3,010	35.7	12.9	1,978	23.5	...	1,032	133
1861-1865	77,040	624	8.1	2,663	34.6	...	1,915	24.9	...	748	130
1856-1860	73,458	524	7.1	2,397	32.6	...	1,772	24.1	...	625	126

* Corrected for transferred births for 1911 and for transferred deaths for 1904 and subsequent years.

† Civilian Population from 1940 to 1946 inclusive used for death-rate only.

3.—MATERNITY AND CHILD WELFARE.

Some of the changes and developments during the year were—an increase by two in the number of weekly ante-natal sessions; a decision to examine the blood of all expectant mothers for the Rhesus factor; increased use of the mobile child welfare clinic; a start on the erection of new permanent child welfare clinics in the Holburn and Northfield areas; some development at the end of the year in the dental service; the completion of an extension to Pitfodels Residential Nursery and the closing of Thorngrove Residential Nursery; and the completion of an extension to Deeside Day Nursery.

During the year the number of attendances at the post-natal clinic more than doubled; attendances at the ante-natal clinics and at the gynæcological advisory clinic increased in number; more children were brought to the child welfare clinics than in 1953, and far more than in previous years; and a detailed survey was undertaken of all children born in 1953.

(a) EXPECTANT AND NURSING MOTHERS.

(i) Ante-natal Clinics.

Until late in 1954, six weekly ante-natal sessions were held at a central clinic equipped for ante-natal and post-natal work, and single sessions were held at two of the child welfare centres in the City. In the autumn, however, the number of weekly sessions conducted at the central clinic was increased to eight.

Every effort is made to encourage the attendance of expectant mothers at these clinics which, in addition to obstetrical and medical supervision, can provide instruction in mothercraft and make the expectant mother more fully aware of the physical and emotional needs of the child. In particular, women for whom institutional confinement has been arranged—80 to 90 per cent. of all expectant mothers in the City—attend the clinics. Of the remaining 10 to 20 per cent. who are under the care of general practitioners and/or municipal midwives, a considerable number also attend the clinics for specialist consultation and health teaching.

At the clinics, the co-operation of hospital consultants and midwives on the one hand and of medical and health visiting specialists in health matters on the other hand ensures that the best practicable advice is offered both on clinical and medico-social points and the unusually high percentage of expectant mothers attending the clinics is undoubtedly causally related to the low still birth-rate, maternal death-rate, and neo-natal death-rate normally obtaining in the City.

At the close of the year, the distribution and medical staffing of the sessions were—

Castle Terrace—4 sessions—staffed by 1 consultant, 1 assistant medical officer of health, and 1 resident medical officer.

Castle Terrace—2 sessions—staffed by 1 consultant and 1 resident medical officer.

Castle Terrace—2 sessions—staffed by 1 consultant.

Torry—1 session—staffed by 1 assistant medical officer of health and 1 registrar.

Hilton—1 session—staffed by 1 assistant medical officer of health and 1 registrar.

At each session, health visitors are present in addition to the hospital and local authority medical staff. At the main centre (Castle Terrace), student midwives attend under the supervision of a midwife, and a receptionist and clerkess are also present. To prevent undue waiting, an appointments sytem is in operation at all clinics.

When an expectant mother visits a clinic for the first time, she is promptly interviewed by a health visitor, who allays fears and anxieties, explains the routine of the clinic, and records necessary particulars. The patient is then physically examined by one of the medical staff and is given by the clerkess an appointment for her next visit.

As a rule, samples of blood are taken from every patient for two purposes—performance of the Wassermann test and measurement of hæmoglobin. Until the autumn of 1954, a specimen of blood was examined for the Rhesus factor in the following cases:—

- (a) all parous women without a previous live child;
- (b) all parous women with a history of blood transfusion; and
- (c) all third pregnancies and over.

In recent months, however, the blood of all women attending the clinics has been tested for the Rhesus factor.

(ii) Post-Natal Clinics.

A specialist post-natal clinic is conducted each week at the Aberdeen Maternity Hospital and, in addition, post-natal clinics are held weekly at Castle Terrace (Monday morning), Hilton (Thursday afternoon), and Torry (Monday afternoon) Child Welfare Centres. At the clinic at Castle Terrace, a consultant, an assistant medical officer of health, and a resident medical officer are in attendance, while, at Hilton and Torry, there are an assistant medical officer of health and a registrar who examine both post-natal and ante-natal cases during the weekly session.

(iii) Teaching of Mothercraft.

At all the ante-natal and post-natal clinics, health visitors give advice on mothercraft and, for more systematic instruction, a special clinic session is held once a week at the Castle Terrace Centre. It is hoped that it will be possible to expand considerably this instruction in the near future.

(iv) Attendances at Ante-Natal and Post-Natal Clinics.

The table below shows the numbers attending and the number of attendances made at the ante-natal and post-natal clinics during 1954, with, for comparison, similar figures for 1953, 1952, and 1951. It will be noted that the number of women attending the ante-natal clinics approximates closely to the number of births during the year. It will also be noted that the number of attendances at ante-natal clinics has increased in 1954, while the number of attendances at post-natal clinics has more than doubled.

ANTE-NATAL CLINICS.		POST-NATAL CLINICS.	
No. of Women.	No. of Attendances.	No. of Women.	No. of Attendances.
1954 . . .	3,316	22,037	2,381
1953 . . .	3,392	21,081	1,763
1952 . . .	2,874	21,237	1,786
1951 . . .	3,058	19,658	1,674
			1,771

(v) Gynæcological Advisory Clinic.

This clinic is held at the Castle Terrace Centre, where a specially trained health visitor is in attendance from 9 a.m. to 5 p.m. from Monday to Friday. On Mondays and Thursdays, a departmental medical officer is also in attendance at the morning session. In addition, a medical officer is in attendance on the first Tuesday of every month. The number of mothers who availed themselves of the facilities of the clinic during the year was 671 and they made 2,702 attendances (as compared with 632 and 2,607, respectively, in 1953).

(vi) Supply of Maternity Outfits and Layettes.

Maternity outfits are supplied free of charge to all women who are being confined at home. The contents of the outfit are in accordance with the suggestions of the Department of Health for Scotland.

Wherever possible, mothers are encouraged to provide their own layettes, but a layette is supplied free in exceptional circumstances. In certain cases, mothers are given wool to make garments for the baby. Where a mother is entitled to receive Maternity Benefit, a charge of not less than £2 is made for a complete layette.

(vii) Arrangements for Care of Unmarried Mothers.

(i) Aberdeen Mother and Baby Home.

For a number of years the Corporation have had a standing arrangement with the Aberdeen Mother and Baby Home, Richmondhill House, King's Gate, which is conducted by a voluntary association. Under this arrangement, accommodation is provided for expectant unmarried mothers, and the Corporation pay thirty-five shillings per week towards the maintenance of each woman whom they send to the Home. The women may be admitted and discharged at any time, but the Corporation's responsibility is limited to a period of six weeks before the expected date of confinement and four months thereafter. Women are not confined at the Home but at the Maternity Hospital. During the year, the Corporation accepted responsibility for ten women admitted to the Home.

(ii) Salvation Army Homes.

Arrangements have also been made under which certain expectant unmarried mothers are sent by the Corporation to Salvation Army Homes in either Dundee or Glasgow. The payment made by the Corporation is 14s. per week for six weeks before the expected date of confinement, and 24s. per week for four months thereafter. During the year, three women were sent to the Salvation Army Homes.

The total number of illegitimate births for the City during the year under review was 140, as compared with 138 in 1953 and 172 in 1952.

(b) CHILD WELFARE.

(i) *Child Welfare Centres.*

Three general points may first be mentioned:—

- (a) As in most other areas, the public demand for child welfare clinics is continuing to increase; it will be noted that the number of children attending was higher in 1954 than in 1953, and higher in 1953 than in 1952.
- (b) With the development of various new housing areas, the provision of clinics is becoming increasingly difficult; and
- (c) The scope of a child welfare clinic is tending to widen; it now includes far more than just advice on physical health.

There are ten child welfare centres in the City, apart from the mobile unit.

Four full-time Child Welfare Centres are maintained at Castlegate, Charlotte Street, Hilton, and Torry, respectively. These are open daily from 9 a.m. to 5 p.m. with health visitors constantly in attendance, so that mothers may come at any time for skilled advice. At all clinic sessions, where a doctor is in attendance, vaccination against smallpox and immunisation against diphtheria and whooping cough are carried out. Clinic sessions are also held for baby weighing and advice about the care of children. Special morning sessions are reserved for advising mothers on infant feeding. For the examination of children by the medical staff, an appointments system is in operation and functions satisfactorily, thus saving mothers from needless waiting.

A fifth clinic, which may ultimately become a full-time one, is held at No. 1A, View Terrace. So far, four sessions a week have sufficed at this clinic which serves the Rosemount area of the City.

In addition, weekly clinics are held at four other centres, viz.:—St. Machar's Church Hall; Powis Community Centre; the Lads' Club, Gallowgate; and Ruthrieston. A consultant or a registrar from the Aberdeen Hospital for Sick Children attends the Ruthrieston Clinic weekly.

At Hayton, a clinic is conducted thrice weekly.

(ii) *Mobile Unit.*

A mobile unit has now been in operation for two-and-a-half years. The unit—the first used for child welfare work in any town in Scotland—was specially designed to provide facilities for expert medical examination and for immunisation and vaccination in the minimum amount of space.

It is staffed by a departmental medical officer and a health visitor. The same doctor attends at most sessions, but the health visitor varies with the district served. There is also a driver who, after uncoupling the unit from the van which tows it, is available for other duties while the unit is operating at any one point.

By the end of 1954, the clinic was operating in eight areas as follows:—Kaimhill (Monday afternoon), Stockethill (Tuesday mornings and Thursday afternoons), Smithfield (Tuesday afternoons), Holburn (Wednesday mornings), Inverdee

(Thursday mornings), Cummings Park (Friday mornings), and Northfield (Friday afternoons).

(iii) *Future Plans.*

Although the mobile unit is of unquestioned value in providing facilities for skilled examination and advice in those parts of the town that are in process of becoming built up, it cannot fully cope with the needs of a densely-populated area. Indeed, its very success in areas like Holburn and Northfield demonstrates the need for permanent clinics in these areas. At the end of 1954, work had commenced in the erection of permanent clinics in the Northfield and Holburn districts.

(iv) *Attendances at Child Welfare Clinics.*

The number of children who attended the child welfare clinics during the year, and the number of attendances were as follows:—

Total number of children under 5 years of age who first attended at the clinics during the year—

(a) Under 1 year of age, 2,589; (b) over 1 year of age, 3,842.

Total number of attendances made by children during the year—

(a) Under 1 year of age, 27,005; (b) over 1 year of age, 16,119.

(v) *Facilities for Consultant Advice.*

Consultants do not attend at any of the Child Welfare Centres. If any condition is found on which expert clinical advice is required, the mother is told to take her child to her general practitioner who is advised of the condition, and may, thereafter, seek the advice of an appropriate consultant. The system works reasonably satisfactorily.

(vi) *Ultra-Violet Light Clinics.*

On the recommendation of an assistant medical officer of health, debilitated children can receive ultra-violet light treatment at clinics which are held for that purpose twice weekly at the Charlotte Street, Hilton, and Torry Centres.

(vii) *Orthopaedic Clinics.*

An arrangement has been made with the Principal of the Dunfermline College of Physical Training whereby the Corporation's medical staff may send children suffering from postural defects to a clinic held in the College at Woolmanhill, where remedial exercises are given. This arrangement, in addition to being highly beneficial to the children, is very useful to students.

Pre-school children suffering from other orthopaedic defects are referred to an orthopaedic clinic which is now also held at Woolmanhill. The children attending this clinic are examined by an orthopaedic surgeon from the North-Eastern Regional Hospital Board.

(c) CARE OF PREMATURE INFANTS.

All premature babies born at home are forthwith transferred to the special ward at the Royal Hospital for Sick Children. This enables such babies to secure skilled medical attention and continuous nursing, and gives them the best chance

of survival. When it is considered that the babies can safely be sent home, the Health and Welfare Department is notified, and the appropriate health visitor immediately visits the home to ensure that everything necessary is done for the baby. In certain instances, equipment, such as cots, cot blankets, &c., is issued on loan, and the health visitor gives special instruction to the mother on the care of the baby.

(d) SUPPLIES OF DRIED MILK, &c.

During the year, the Corporation assumed responsibility for the issuing of cod liver oil, orange juice, and National dried milk. These are supplied at each of the Child Welfare Centres (and vitamin A and D liquid (Adexolin) is distributed free of charge to necessitous cases) and are also available at a centrally placed distribution centre and several shops throughout the City.

Certain proprietary milk foods are also issued at reduced prices at the discretion of the medical officer at each clinic.

(e) DENTAL CARE.

The authorised establishment in the dental section comprises a chief dental officer, a senior dental officer, and five dental officers, *i.e.*, seven individuals, and there were three vacancies at the beginning of the year and four at the end. However, at the end of the year there seemed to be some hope of the vacancies being filled, and developments were beginning to take place in the dental service.

It should be mentioned that (as indicated in the Report for 1953) the Local Dental Committee has been approached about the possibility of giving part-time or sessional assistance, but is unable to help.

To such very limited extent as staffing shortages have permitted, patients have been referred to the dental clinic by the medical officers who examine expectant mothers and young children at the ante-natal and child welfare clinics. The following figures show the work which the dental officers undertook during the year, data for 1953 being given in parenthesis for purposes of comparison:—

	Examined.	Found to need Treatment.	Treated.
Expectant and nursing mothers	0 (0)	0 (0)	0 (0)
Pre-school children	137 (20)	78 (20)	51 (32)

In other words, the local authority dental service in respect of pre-school children and expectant and nursing mothers was still virtually non-existent in 1954.

It must be made clear that no blame for this lack of services attaches to the Corporation. The lack has been caused by inability to secure staff despite frequent advertisements.

(f) OTHER PROVISIONS FOR EXPECTANT AND NURSING MOTHERS AND YOUNG CHILDREN.

(i) Residential Nurseries.

At the beginning of the year the Corporation had two residential nurseries—Thorngrove (with 21 places) and Pitfodels House (which had accommodation for 50 children). Both nurseries were recognised for the training of nursery students.

An extension to Pitfodels House was completed in the middle of 1954, providing 82 places at that nursery, and in July the small nursery at Thorngrove was closed.

The residential nursery is used for the children of parents who, for an adequate reason (such as mother in hospital), cannot look after their young children. Children taken into the care of the local authority and under two years of age are also accommodated.

(ii) *Day Nurseries.*

The adequacy of day nurseries for the needs of the City was under review during the end of the year. At present, the Corporation provide four day nurseries—Charlotte Street (with 60 places), View Terrace (44 places), Deeside (45 places), and Linksfield (30 places). All four have been recognised for training purposes. The Linksfield Nursery continues to be situated in one wing of Linksfield School, but more suitable accommodation has been obtained in another part of the school, and, after certain minor alterations, the children will be transferred to that accommodation. As an experiment, it has been decided to appoint, at Linksfield, a nursery warden who is a qualified teacher holding the Nursery Schools Endorsement, but it is not proposed to proceed with this appointment until the new premises are available. An extension to Deeside Nursery was completed during the year.

4.—DOMICILIARY MIDWIFERY.

There were no important changes in the midwifery service during the year, except the appointment of an additional midwife. The number of domiciliary confinements rose to 479, and the number of domiciliary births at which a doctor was present fell to 29. All the midwives are now qualified to administer gas and air analgesia.

General.

The midwifery staff at the end of the year consisted of a Supervisor of Midwives (who also functions for the greater part of her time as Superintendent Health Visitor), an assistant, and nine whole-time midwives. A district of the City is allocated to each midwife. In addition, the Corporation have an arrangement with the Board of Management for the Aberdeen Special Hospitals whereby a central district of the City is served by three midwives on the staff of the Aberdeen Maternity Hospital, and the Corporation pay £825 per annum towards the remuneration of these midwives. The small number of midwives is explained by the fact that the majority of confinements in Aberdeen take place in hospital.

The Supervisor of Midwives is responsible for the supervision of all practising midwives in the City—not only those on the staff of the Corporation. At present, there is one midwife in private practice in the City, and sixty-three midwives are employed in hospitals or nursing homes. During the year, 381 confinements were attended by municipal midwives and 95 confinements by midwives employed by the

Board of Management for the Aberdeen Special Hospitals, a total of 476 (as compared with 471 in 1953 and 417 in 1952).

Births.

Particulars of the births, including still-births, which occurred in the City during 1954, are as follows:—

- (i) Total number of births occurring in the area during year— that is, before correction for mothers' residence:—Live births, 4,026; still-births, 91. Total 4,117
- (ii) Total number of above births occurring in institutions (including private maternity homes) 3,638
- (iii) Total number of above births occurring at home 479

These 479 may be further sub-divided thus to show attendance at birth:—

	Doctor engaged and present.	Doctor engaged but not present.	No doctor engaged.	Total.
Municipal midwives	24	350	7	381
Hospital midwives "on district"	5	70	20	95
Private practising midwives	—	—	—	—
No midwife	—	2	1	3
Total	29 (6.1%)	422 (88.1%)	28 (5.8%)	479
Comparable figures for 1953	31 (6.5%)	412 (86.7%)	32 (6.7%)	475
Comparable figures for 1952	44 (10.4%)	355 (83.9%)	24 (5.7%)	423

Administration of Analgesics.

All the domiciliary midwives are qualified to administer gas and air analgesia; three sets of gas and air apparatus were in use at 31st December; and gas and air analgesia was administered by midwives in 400 cases during the year, while pethedine was administered in 251 cases. The comparable figures for 1953 were 375 and 220 respectively.

Use of cars.

At the end of the year no municipal midwife had a car.

Arrangements for ante-natal supervision by Midwives.

When a confinement is expected to take place at home, ante-natal supervision is given by the midwife concerned either in a duty room set aside for that purpose in the midwife's house or at the woman's own home. This supervision is given from the time of booking the midwife, and weekly visits are paid to the women's own home during the last month. If any personal or environmental circumstances make it desirable that a confinement, originally booked as domiciliary, should in fact take place in hospital, the general practitioner and the midwife advise the woman accordingly. Wherever possible, however, arrangements for admission to hospital on social grounds or on grounds of anticipated obstetrical difficulty are made early in the pregnancy.

Refresher Course for Midwives.

During the year a refresher course for midwives was held in Dumfries. This course was conducted under the auspices of the Royal College of Midwives and the Queen's Institute of District Nursing. The course extended from 20th to 27th March, and the Superintending Nursing Officer and a midwife attended this course at the Corporation's expense.

Training of Pupil Midwives.

The Aberdeen Maternity Hospital is, of course, a training hospital, but, as part of their training, midwives must obtain experience in domiciliary confinements under supervision. This is arranged through three midwives stationed at No. 32, Carden Place, and the Supervisor of Midwives gives lectures to the students before they begin their domiciliary work.

5.—HEALTH VISITING.

A "paper" development in 1954 was an increase in the authorised establishment to 85, but, owing to the grave national shortage of health visitors, the number actually employed rose only from 58 to 61. As mentioned in another section of the report, a major innovation during the year was a post-qualification course in mental health. Efforts were made during 1954 to improve liaison between general practitioners and health visitors.

The use of health visitors in the training of medical students was continued and, in addition, student nurses in Aberdeen Royal Infirmary were introduced to the work of a health department.

General.

The National Health Service (Scotland) Act, 1947, enormously extended the role of the health visitor. Section 24 of the Act, placed on local authorities a duty to make provision for the visiting of persons in their homes by health visitors to advise on the care, not only of expectant and nursing mothers and young children, but also of persons suffering from illness and on the measures necessary to promote health and to prevent the spread of infection. The duties of health visitors are, therefore, now statutory and are very much wider than they were before 1948. Instead of being concerned simply with the care of children and the prevention of infectious disease, the health visitor has become a recognised health adviser of the whole family, concerned with general promotion of physical and mental fitness, prevention of disease, and advising on the care and after-care of the sick. She is the person to whom a housewife can turn for advice on family budgeting, household economics, dietetics, personal hygiene, and matters relating to the physical and emotional health of all members of the family. Two factors, however, have made it impossible as yet for health visitors to cope fully with all the new duties; first, the fact that there has been (and still exists) a grave national shortage of these highly-trained officers;

and second, the fact that the health visitor trained before 1948, although highly skilled in matters relating to the physical health of children, usually had inadequate knowledge of the mental and emotional development of children and virtually no training about the health of adults. Nevertheless, in addition to continuation and extension of the older functions in relation to the care of young children and expectant and nursing mothers, many additional tasks are already being undertaken in Aberdeen. A few points may be selected for mention here. Where a premature baby is returned from the Maternity Hospital to its home, the appropriate health visitor immediately calls and, if deemed necessary, daily visits are paid to give advice to the mother with a view to ensuring that everything possible is done to enable the baby to become a healthy child. Again, health visitors devote much time and energy to encouraging mothers to have their children vaccinated against smallpox and immunised against diphtheria and whooping cough. Then again, the health visitors give weekly talks to the mothers on "Health Education" at four full-time clinics—these talks being in addition to monthly lectures given by medical officers; and, in addition, small groups of mothers who are expecting their first baby are given special talks at five centres in the City. These talks are deliberately given at the Child Welfare Clinics to encourage mothers to bring their babies afterwards to the Clinic.

The prevention of mental and emotional diseases is becoming increasingly recognised as one of the most important facets of a health visitor's work. Indeed, the Secretary of State for Scotland has, himself, drawn attention to the rôle of the health visitor in the prevention of mental ill-health. Reference to in-service training in mental health work is made later in this report in the chapter on Training of Health Visitors.

Already there are over 20,000 people of pensionable age in the City, and the health care of the elderly is a field which, in magnitude, will probably ultimately be as large as that of child welfare. Although the number of health visitors is not yet anything like adequate, an increase during the year enabled a considerable development to take place in respect of the visitation of old people. Elsewhere in the report, reference is made to a Study Day in the health care of the elderly. At the end of the year, regular visits were being paid to some 723 elderly persons, as compared with 300 at the close of 1953. Schemes were also developed during the year for improved services for cripples and physically-handicapped persons.

In Aberdeen, to enable public health nurses to get to know more closely the families that they are advising, and to save any one household from receiving visits from several nurses, health visitors also act as school nurses, and it is intended that they should in general also act as welfare visitors in respect of cripples and handicapped persons.

In order to provide an efficient health-visiting service, the Corporation, having in 1953 decided as an interim measure to increase the establishment of health visitors to 75, decided at the close of 1954 to increase it to 85, although, owing to shortages of recruits nationally, it is unlikely that the figure will be achieved before 1960. It will be recalled that the sanction of the Secretary of State has already been obtained

for an ultimate establishment of 100. The increase in numbers actually employed is gradually taking place. At the end of 1954, there were 61 health visitors in the employment of the Corporation. These included six doing tuberculosis work, one working largely in connection with infectious diseases, one acting as supervisor of day nurseries, and two acting as superintendents of home helps.

Staff Shortages.

Fifty-eight health visitors (at 1st January) out of an interim establishment of 75 represents a shortage in the neighbourhood of 25 per cent. Sixty-one health visitors (at 31st December) out of a complement of 85 represents a shortage of 30 per cent. Sheer scarcity has inevitably limited the extent to which new services can be developed. Again and again the immediate need has been to decide, not between the highly desirable and the desirable, but between the highly desirable and the essential.

Visitation by Health Visitors.

An analysis of the number of home visits made by health visitors during the year is given below, the total visits for 1953 and 1952 being also stated for purposes of comparison:—

	No. Visited in 1954.	1954.	Total Visits. 1953.	1952.
(a) Maternity and Child Welfare—				
Expectant mothers	2,447	8,745	8,420	7,335
Children under 1 year	3,094	24,889	28,930	31,797
Children aged 1-5 years	11,842	59,291	64,748	46,039
(b) Cases of tuberculosis	1,649	10,882	9,988	7,002
(c) Other cases	2,428	4,611	2,730	5,015

In all, 108,418 home visits were paid, as compared with 114,816 in the previous year. It must, of course, be appreciated that, in addition to home visits, a good deal of work of the health visitors is carried out at Child Welfare Centres throughout the City. In point of fact, nearly 30 per cent. of their time is spent in clinic work and about another 20 per cent. in schools.

Liaison with Hospitals.

This is very close in the case of some hospitals, *e.g.*, the Maternity Hospital (from which intimation of discharge of patients is always passed to the department and full particulars made available), the infectious diseases hospital, and the tuberculosis hospitals (in respect of which six health visitors and an assistant nurse undertake work which might otherwise be done by hospital almoners). In other cases, however, the liaison is less close, although attempts are constantly being made to extend and increase it.

It is perhaps inevitable that, when a patient goes to hospital as a result of sudden illness, the local authority are not made aware of that fact (except in cases of notifiable disease), although in at least a proportion of cases the local authority would be able to provide information of value to the hospital or concrete assistance to relatives of the patient. What is certainly far from inevitable—and therefore

highly distressing—is that patients should be discharged from hospital without any intimation to the local authority, which may thus be deprived of any opportunity to carry out its statutory tasks of care and after-care. The main barrier is, of course, that members of the staffs of hospitals are often quite unaware of the functions and duties of local health authority officers. The development mentioned in the next paragraph may in time do much to remove that unawareness.

A development of great importance followed the decision of the General Nursing Council to include preventive and social aspects of disease in the general nursing curriculum. Starting in the autumn of 1954, student nurses at Aberdeen Royal Infirmary and Woodend Hospital now receive, in their final year, a short course of lectures given by members of the staff of the Health and Welfare Department, and these lectures are followed by visits by each student to private houses, clinics, &c., under the supervision of a health visitor. While this theoretical and practical course can naturally teach the student nurses only the rudiments of disease-prevention and health promotion, it is nevertheless of supreme importance for the future improvement of liaison and co-operation. No two parties can co-operate without some idea of each other's aims and methods of work. Hitherto, the departmental medical officer and the health visitor have understood the aims and methods of their hospital colleagues by reason of the fact that they themselves worked in hospital before specialising in public health; and (as mentioned in the next paragraph) the use of health visitors in the practical training of medical students should ensure that the doctor of the future—whether in hospital or in general practice—knows a little about the preventive service. The new development should complete the circle by enabling the hospital nursing administrators and ward sisters of the future to understand something of what their colleagues in the preventive field are doing.

Liaison with General Practitioners.

In Aberdeen (as in other places) all degrees of co-operation and lack of co-operation are found, but it can be said with confidence that the amount of liaison between general practitioners and health visitors is increasing. It is, however, of the highest importance for the health of the community that every effort should be made to improve the co-operation of the two professional workers in closest touch with the family, the family doctor, and the family health visitor.

In this connection, three points may be mentioned, the first relating to a measure instituted in 1952 and the others relating to measures devised during the year under review.

(a) In each of the last three years, health visitors have been used in the practical training of medical students. Each undergraduate spends the mornings of two weeks in visiting families in their own homes under the direction of a health visitor. Probably no measure yet devised has done more to improve co-operation in the future than this employment of the one professional officer in the training of the other.

Inevitably, this development consumes some of the time of the busy health visitor (and it has to be remembered that other encroachments on her time are in

connection with the training of student health visitors and in connection with home visits now paid by student nurses), but it will undoubtedly pay rich dividends in the future.

(b) During 1954 an attempt was made to convince all health visitors that communication between themselves and general practitioners should as a rule be direct, not through the medium of the medical officer of health or the superintendent health visitor. A memorandum stressing the desirability of direct two-way contact was issued to all health visitors, and the theme was developed by the Medical Officer of Health at a meeting of health visitors. Particular emphasis was laid on these points—that the health visitor could often provide the general practitioner with information of considerable importance, that the general practitioner could frequently give the health visitor information of considerable importance, and that either party could take the initiative in contacting the other.

(c) After at least some health visitors had taken the initiative in endeavouring to develop better liaison with general practitioners, quite a number of practitioners evinced a desire for co-operation and for more knowledge of the special training and duties of health visitors. Through their representatives on the Standing Joint Medical Committee (a committee set up in Aberdeen in 1954 and containing three representatives each from hospital doctors, general practitioners, and public health medical officers), the family doctors asked that, to facilitate co-operation, they be given an indication of the health visitor's professional qualifications and functions. In response, the following memorandum was prepared by the Medical Officer of Health, in consultation with appropriate health visitors, and circulated to all general practitioners in the City:—

MEMORANDUM ON HEALTH VISITORS.

(Prepared for the information of general practitioners at the request of the Aberdeen Standing Joint Medical Committee.)

THE HEALTH VISITOR'S BACKGROUND.

A woman who seeks to qualify as a health visitor must start by becoming a fully-trained nurse and taking a further training in midwifery. Then, usually after working for several years as a hospital staff nurse and ward sister, she has to take yet another training in health visiting. The course for the health visitor's certificate is given in three University cities (which can provide the necessary variety of lecturers) and consists of two terms (in some training centres, a complete academic year) of full-time instruction in such subjects as health education, methods of imparting information to individuals and to groups, social and environmental aspects of disease, mental and physical development of children and adolescents, hygiene, and the prevention of physical and mental disease.

A health visitor is therefore a highly-trained professional worker who is well equipped for her primary task of acting as a health counsellor and health adviser in the community.

HER DUTIES.

Until 1948 she was concerned almost solely with health advice to expectant and nursing mothers, the health and well-being of pre-school children, and (as school nurse) the health of school children. The National Health Service (Scotland) Act extended her duties considerably: Section 24 of that Act conferred on her statutory duties in respect of

"giving advice as to the care of young children, persons suffering from illness, and expectant and nursing mothers, and as to the measures necessary to promote health and to prevent the spread of infection":

and Section 27 mentioned

"the prevention of illness, the care of persons suffering from illness or mental deficiency, or the after-care of such persons."

Broadly, a health visitor is to be regarded as a person whose main task is to act as a family health teacher. Her basic duty is that of teaching and guiding individuals and families to become physically and mentally healthier by their own efforts and to accept their family and community responsibilities.

Some of her many duties may be summarised thus:—

(a) *Maternity and Child Welfare.*—Regular home visits to advise on infant feeding and development and on the physical, mental, and emotional aspects of the health of expectant mother and young child, including not merely the prevention of physical diseases but the prevention of the disturbed parent-child relationships and the inconsistencies in the handling of children in which so often lie the seeds of mental and psychosomatic illness. Teaching of parentcraft in homes, at ante-natal clinics, and at child welfare clinics.

(b) *School Nursing.*—Acting as a link between home and school, with knowledge of both; health surveys, i.e., seeing every child each term and paying special attention to evidence of insufficient sleep, faulty diet, defects of special senses, bad posture, &c.; follow-up home visits; health education of children and their parents; and advice to teachers on health matters.

(c) *Tuberculosis.*—(In Aberdeen, work is undertaken by six specialist health visitors, not by all health visitors.) Tracing and follow-up of contacts; reports on social and physical environment of patient; health education of patient and his family during illness and afterwards; helping patient to adjust emotionally to his disease; arrangements for after-care.

(d) *Infectious Diseases.*—Prevention by home teaching of rules of health and of need for immunisation and vaccination; follow-up of contacts; advice on after-care.

(e) *Mental Health.*—Advice on maintenance of proper parent-child relationships and on prevention of frustration, over-strictness, over-licence,

and mismanagement—all of which can lead both to behaviour difficulties and to neuroses.

(f) Care and After-care of Illness.—*Health advice, and bringing in of the various services needed for the welfare of the patient and his family. (Duties do not include home nursing, since this can be adequately done by nurses without subsequent public health training.)*

(g) Health and Welfare of the Aged.—*In people who are still reasonably healthy, prevention of premature senescence, e.g., by advice about habits, leisure interests, work, diet, hygiene, and exercise. In people already frail, assessment of their needs for such services as chiropody, meals-on-wheels, home helps, help from voluntary agencies, and admission to hostels, and advice about obtaining these services and about pensions, allowances, &c.*

(h) Prevention of Home Accidents, e.g., *by systematically making parents aware of the developmental needs of their children and of the special dangers associated with each stage of development; and similarly by making old people aware of dangers resulting from their particular disabilities (e.g., sight) and environments.*

(i) Home Management, e.g., *advice to the re-housed on the innumerable problems that arise (finance—increased rent and transport; changed environment—loneliness and isolation, &c.).*

ADMINISTRATION OF THE HEALTH VISITOR SERVICE.

Health visitors work under the general administrative direction of the Medical Officer of Health, assisted by the Superintendent Nursing Officer. However, since each health visitor is a highly trained professional woman working on her own in her district, it is manifest that such administrative direction cannot mean supervision and detailed instructions.

In this connection, a sharp contrast may be drawn between the health visitor and the home nurse. The home nurse, nursing a patient under treatment by a general practitioner, is in the position of carrying out his instructions. The health visitor, undertaking her statutory duties of health teaching and social education, is essentially an independent worker although it is often necessary for her to co-operate with the family doctor, the school teacher, the psychiatric social worker, the sanitary inspector, and various voluntary agencies.

CO-OPERATION OF GENERAL PRACTITIONER AND HEALTH VISITOR.

It is obviously greatly to the benefit of the family that the general practitioner and health visitor should, wherever possible, co-operate rather than work in isolation. Moreover, where a general practitioner and a health visitor are separately visiting a household without any contact with each other, the duplication of effort does not necessarily mean double benefit, and may even be harmful through conflicting advice. Again, there must be quite a number of cases in which a doctor or health visitor alone would need to make extensive enquiries to solve a medical or

social problem, and in which a few words from the other with a differing background of knowledge would throw new light on the problem and make the enquiries superfluous.

Half-a-dozen examples may illustrate.

(1) *Where a baby is failing to gain weight without obvious cause, the general practitioner might be saved considerable investigation if the health visitor, from her detailed knowledge of the home, were able to explain that immature parents were handling the child too much and not allowing it sufficient rest.*

(2) *Where the health visitor hesitates to give advice because a baby is attending the doctor and yet feels doubtful about whether the mother is really carrying out the doctor's instructions, it would clearly be helpful if the health visitor learned from the doctor exactly what he had advised.*

(3) *The general practitioner investigating a case of enuresis might be appreciably helped if the health visitor could let him know that there was considerable marital disharmony between the parents or that there was a dominating grandmother.*

(4) *The health visitor concerned about the pallor of the mother of a young family might be helped if the general practitioner stated that he had already done a blood count and excluded the anæmias or begun to treat the disease.*

(5) *Much of the time of a general practitioner treating an elderly patient might be saved if he knew that the health visitor had already set in motion the machinery for providing a home help or meals-on-wheels.*

(6) *The health visitor anxious to rescue an old man from apparent apathetic refusal to get out of bed might benefit from knowing that the general practitioner had diagnosed serious organic disease or had excluded it.*

QUESTION OF CONFIDENTIALITY.

The general practitioner, as private medical attendant of a patient, often learns things that the patient has not revealed to the health visitor. The health visitor, through her frequent visits to the house, often learns things that the patient does not reveal to the general practitioner whom he sees less often. It would be useful if doctor and health visitor each realised that the other was a highly trained professional person who could in general safely be regarded as coming within the bonds of confidentiality.

HOW CO-OPERATION CAN BE ACHIEVED.

Co-operation implies three things—knowledge by each person of the functions, responsibilities, and special skills of the other; willingness to seek the help of the other in appropriate cases and to give help where it is sought; and easy, frequent direct, two-way communication.

Medicine is an older profession than health visiting, and it can be taken for granted that all health visitors are already well aware of the duties and skills of the family doctor. As some doctors may not yet be fully aware of the responsibilities and skills of the modern health visitor, this memorandum has started with a brief outline of her basic training and main duties.

Mutual requests for help will probably follow automatically if there is goodwill on both sides.

The real difficulty is to provide easy and satisfactory channels of communication. Some of the difficulties in the way of such communication are—

- (a) *Sheer numbers—there are some 77 general practitioners and some 60 health visitors in the City;*
- (b) *Scattered areas of general practitioners' practices which, in at least some cases, extend all over the City;*
- (c) *The fact that, while, for every family, there is a family health visitor, there are some families which do not have a family doctor, e.g., two members of a household may have different medical attendants;*
- (d) *The fact that, while approximately two-thirds of the health visitors have clearly defined districts, the remaining third are engaged on specialist duties and an individual doctor cannot reasonably be expected to know whether a particular case would fall within the sphere of the family health visitor for the particular district or of a health visitor handling specialist work;*
- (e) *The fact that the health visitors do not as a rule have telephones in their houses.*

The following suggestions are offered in the hope that they may enable some of the difficulties to be overcome.

1. APPROACHES TO GENERAL PRACTITIONERS BY HEALTH VISITORS.

Where a health visitor feels that it would be in the interests of any individual or family that she is visiting for her to make contact with the general practitioner, it should be easy for her to ascertain the name of the doctor concerned and to approach him either by telephone or otherwise. While such approach is often particularly desirable in cases originally referred to the Health and Welfare Department by the doctor, there is nothing to prevent a health visitor from taking the initiative in other cases.

2. APPROACHES TO HEALTH VISITORS BY GENERAL PRACTITIONERS.

(a) *Initial approach to Health and Welfare Department.—Probably the easiest method of initial contact is for the doctor to write or telephone to the Department (usually to the Superintending Nursing Officer), giving broad outlines of the case and for the letter or transcript of the telephone call to be passed to the appropriate health visitor, who can then contact the doctor for fuller information, if necessary.*

This method has advantages in that the general practitioner will not always know which health visitor has the district in which the patient lives, the general practitioner may not know whether the case is of a type that would normally be allocated to a specialist health visitor instead of to the district health visitor, and it is useful for the Department to have information about the types and numbers of cases for which help is being sought.

(b) Initial approach to Health Visitor.—*If the general practitioner knows which health visitor is responsible for the district in which a particular patient lives, there is nothing to hinder him from making the initial approach directly to the health visitor. If it should happen that the health visitor feels that the case is not appropriate for her (e.g., that it is outside her district or that it is a case that would normally be handled by a specialist health visitor), she can easily enough explain this to the doctor and suggest that he makes his request to the Department as indicated in (a) above. If, however, the health visitor feels that the case is appropriate to her, she can then take action, and a certain amount of time will have been saved.*

(c) Approach in cases in which the Health Visitor is already visiting a house.—*Where a health visitor is already visiting a house, it should be easy for the general practitioner to ascertain her name and to make direct contact with her.*

6.—TRAINING OF HEALTH VISITORS.

Developments during the year included the appointment of a second health visitor tutor, a repetition of the remarkable examination success achieved in 1953, and the introduction of in-service training for qualified health visitors.

Origin of Training School.

Until 1948, there were only two training schools in Scotland—attached to the Health Department of Edinburgh and Glasgow, respectively—in which state-registered nurses with the necessary midwifery qualification could take the additional full-time course to enable them to sit the national examination for the health visitors' certificate. The vast extension of the work of the health visitor under the National Health Service Act, 1947, made it obvious that two training schools would be inadequate to meet the needs of the country, and the Corporation of the third largest city in Scotland, therefore, decided to establish a training school.

Premises were ultimately made available and equipped at 6, Castle Terrace: a qualified health visitor tutor was engaged to take charge of the school and to supervise the practical and theoretical training of the students; and arrangements were made for lectures to be given by appropriate professors and lecturers from Aberdeen University, consultants employed by the North-Eastern Regional Hospital Board, members of the staff of the Health and Welfare Department, and other suitable persons,

Development and Results.

The Training School has been badly hampered by inadequacy of accommodation (a defect which will persist until the School can be transferred to more commodious and suitable premises), by unsuitable furniture (a defect partially remedied during 1954), and by lack of a proper library and of sufficient teaching equipment (defects which are in process of being overcome). Nevertheless, it has done outstanding work. Indeed, in 1952-53 it had the remarkable double triumph of securing a hundred per cent. pass of candidates in the national examination and of training the student who took the top place in that examination, and in 1953-54 it repeated that double triumph. This dual success, a thing of considerable merit in any year, was all the more significant in 1952-53 because in that session a newly appointed tutor achieved it during her first year of office.

During 1953, the Corporation became aware that—despite the excellent results obtained—a single-tutor school was really an anachronism and that, if post-qualification training of trained health visitors was also to be undertaken, the appointment of a second tutor was imperative. Accordingly, early in 1954, a second qualified health visitor tutor was engaged.

A project for extending the accommodation of the school (principally by provision of a second lecture-room and a students' study) was under consideration during 1954, but was deferred pending consideration of the availability of other—and probably more satisfactory—premises.

As mentioned elsewhere in this report, Miss D. J. Lamont, Principal Health Visitor Tutor, received in 1954 the signal honour of the award of a World Health Organisation Senior Travelling Fellowship. This is the first occasion on which such an award has been made to a public health nurse in this country.

Number of Students trained.

The Training School has proved most beneficial for the recruitment of health visitors not only for the service of the Corporation but also for service in less populous areas. With the existing shortage of these officers, this is a point of considerable importance. The number of students trained each year and the number subsequently employed by the Corporation were as follows:—

Year.	Total Number of Students.	Number later Employed by Corporation.
1948	20	6
1948-49	20	8
1949-50	19	7
1950-51	21	9
1951-52	19	7
1952-53	20	10
1953-54	17	4
1954-55	22	... Still in training.

In-Service Training of Health Visitors.

Health visitors trained before 1948, and even those trained shortly after 1948, were given instruction mainly in the old aspects of a health visitor's work—advising

about the physical aspects of the health of children, prevention of infectious disease, &c. They received very little, if any, training in the promotion of mental health, the prevention of diseases of mental and emotional origin, sociological aspects of health and disease, the health care of the elderly, and the application of the techniques of health education to the non-infectious diseases. To equip these health visitors for their important new duties, post-qualification training is essential.

Two major developments took place in 1954. In the first place, a forty-to-fifty-hour course on mental health was given to twenty of the fifty health visitors who volunteered to take it. The course was held partly in the health visitors' own time (evenings) and partly in official time (Saturday mornings). Suitable lecturers were found (not without difficulty), and the two health visitor tutors acted as co-ordinators of the course and discussion leaders. The experiment was an outstanding success and should do much to enable the participators to discharge more fully their important duties in relation to mental health. It is hoped that a similar course will be conducted in 1955.

In the second place, study days on individual subjects were introduced. The first study day was devoted to the health-care of the elderly, the speakers being Dr. Fergus Anderson (Geriatric Physician, Western Regional Hospital Board), Dr. N. R. Cowan (Medical Officer of Health, Rutherglen), Dr. D. Barclay (Principal Assistant Medical Officer of Health, Aberdeen), Miss D. J. Lamont (Principal Health Visitor Tutor, Aberdeen), and the writer of this report. The response of the health visitors as a whole was enthusiastic, and augurs well for future study days.

7.—HOME NURSING.

During the year there were, for the second year in succession, increases in the numbers of patients treated and of visits paid by the day nursing service, and, following some re-organisation of the night service, increases in numbers of patients treated and numbers of visits paid.

General.

Aberdeen is one of the twelve local health authorities that do not themselves employ district nurses. The Corporation discharge their duty to secure the attendance of nurses on persons who require nursing in their own homes through the agency of the Aberdeen District Nursing Association, the expense being met by the Corporation. The Lord Provost, the Treasurer, the Convener of the Health and Welfare Committee, and one other Councillor, together with the Medical Officer of Health, are members of the Committee of the District Nursing Association, and, during the last two years, the Superintendent Nursing Officer has been co-opted to the Committee.

Co-operation.

As might be expected, the majority of the cases dealt with by the nurses employed by the Nursing Association are referred to them by general practitioners, although quite a proportion are discovered by the health visitors and referred

through the Health and Welfare Department. Also in cases where a patient is discharged from hospital and requires nursing attention, an almoner at the hospital may contact the Superintendent of the Nursing Association to arrange for a nurse to provide that attention.

There is a standing arrangement that each month a list of old people who are convalescent and no longer require nursing attention is furnished by the Nursing Association to the department, so that appropriate health visitors can pay periodic visits to the old people to ensure that they are getting any necessary assistance, *e.g.*, home helps, meals on wheels, &c.

Classification and proportions of main types of cases.

The number of patients visited during the year was 4,920, as compared with 4,373 in 1953 and 4,115 in 1952, and the total visits paid, 102,860 as compared with 88,870 in 1953 and 82,788 in 1952. It is interesting to note that over 40 per cent. of the patients were over the age of 65 years.

The classification and proportions of the main types of cases dealt with by the nurses employed by the Nursing Association are as follows:—

Classification and Proportions of Main Types of Cases Nursed in 1954.

DAY NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases			
	M.	F.	Total	M.	F.	Total	- 65	65+	Conv.	Transfer to Hosp.	Died	Con- in 2 31st d.
Abdominal . . .	392	533	925	4,596	3,448	8,044	558	367	760	46	52	
Accidents . . .	85	146	231	902	3,119	4,021	155	76	180	14	5	
Amputations . . .	13	10	23	348	360	708	12	11	11	2	1	
Anæmia . . .	9	76	85	224	2,005	2,229	33	52	24	4	4	
Cancer . . .	81	129	210	2,356	5,611	7,967	91	119	37	26	116	
Cardiac . . .	203	282	485	4,509	8,440	12,949	178	307	160	80	95	
Cerebral Hæm. . .	77	190	267	2,587	7,329	9,916	51	216	71	42	86	
Diabetes . . .	21	90	111	1,997	13,872	15,869	29	82	31	19	8	
Gynæcological . . .	—	86	86	—	1,194	1,194	72	14	73	1	3	
Miscellaneous . . .	441	935	1,376	5,797	13,235	19,032	1,093	283	1,081	91	77	
Nervous . . .	22	51	73	826	1,605	2,431	51	22	33	10	5	
Respiratory . . .	219	268	487	2,570	3,218	5,788	313	174	377	36	37	
Rheumatism . . .	28	122	150	614	4,241	4,855	63	87	65	18	16	
Varicose Ulcers . . .	19	68	87	668	4,229	4,897	31	56	46	9	3	
Total . . .	1,610	2,986	4,596	27,994	71,906	99,900	2,730	1,866	2,947	398	508	

Staff.

The staff of the day nursing service totalled 37 at the end of the year (including the Superintendent and two assistants). The night nursing staff are mentioned separately below.

Night Nursing Service.

The night nursing service, inaugurated early in 1952, and slightly extended and somewhat re-organised during 1953 in the light of the experience gained during

the first year of operation, underwent little alteration during 1954. The service has already proved very useful. Its main function will probably ultimately be the provision of occasional skilled nursing (*e.g.*, visiting patients for four-hourly injections of penicillin or for injection of pain-killing drugs), but, in its initial stages, it has served mainly to provide nursing care for persons living alone or for persons whose relatives were exhausted from looking after the patient on previous nights. In December the staff employed on night work amounted to four trained nurses and two assistant nurses on a full-time basis and four trained nurses on a part-time basis. In all, 324 cases were attended during the year, and 2,960 visits were made (as compared with 265 patients and 2,683 visits in 1953 and 175 patients and 1,884 visits in 1952).

Details of the cases dealt with are given in the following table:—

NIGHT NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases				
	M.	F.	Total	M.	F.	Total	- 65	65 +	Conv.	Transfer to Hosp. Hosp. P. Nurse	Died	Continuing at 31st Dec.	
ominal . .	1	10	11	1	115	116	3	8	5	2	1	3	—
mia . . .	1	2	3	22	18	40	1	2	2	—	—	—	1
er . . .	27	35	62	255	403	658	24	38	9	4	—	48	1
iac . . .	21	20	41	228	125	353	9	32	6	9	—	22	4
oral Hæm.	28	53	81	274	472	746	13	68	29	10	—	34	8
ellaneous .	16	28	44	43	132	175	18	26	20	11	4	4	5
ous . . .	3	3	6	25	46	71	2	4	3	2	—	1	—
iratory . .	12	22	34	167	154	321	9	25	16	4	3	9	2
matism . .	—	2	2	—	119	119	1	1	—	—	—	—	2
ity . . .	10	30	40	121	210	331	—	40	12	8	—	20	—
Total . .	119	205	324	1,166	1,794	2,960	80	244	102	50	8	141	23

Training of District Nurses.

The Association undertakes training for the Queen's Certificate. At the end of the year six students were receiving training.

8.—DOMESTIC HELP SERVICE.

During the year, the number of domestic helps employed was increased to the maximum figure authorised by the Corporation, and at the end of the year the authorised establishment was raised to 100 full-time helps or an equivalent number of part-time helps. The increase in the establishment is, of course, an indication both of the high value of the service and of the need for further development. The approval of the Secretary of State has been obtained for an ultimate extension of the number employed to 200.

Households which may qualify for the domestic help service (whole-time or part-time) include those where there is a sick person, an expectant mother, a mentally defective person, an elderly person, and certain other categories. A charge is made

for the home help, and is based on the applicant's income. In the lowest income group (persons on national assistance), the minimum charge is refunded by the National Assistance Board.

The following is a table showing the number of domestic helps in the service at December, 1954, as compared with 1953 and 1952:—

	1954.	1953.	1952.
Whole-time	44	36	36
Part-time	97	52	39

The great demand in Aberdeen is for part-time service, especially in the mornings, but considerable difficulty is being experienced in obtaining suitable helps when only part-time work can be offered to them. The following statement shows the distribution of the cases attended during 1954, as compared with 1953 and 1952:—

	1954.	1953.	1952.
(a) Maternity and Child Welfare cases . . .	236	208	207
(b) Infirm and elderly cases (over 65) . . .	420	287	225
(c) Long-term illnesses (other than (b)) . . .	75	53	32
(d) Short-term illnesses (other than (a) or (b)) .	339	351	343

It will be noted that there is a sharp increase in the number of elderly, infirm persons attended in 1954. The question of a sitter-in service has not yet been considered by the Corporation.

9.—VACCINATION AND IMMUNISATION.

The number of primary vaccinations against smallpox remained fairly steady, the proportion of children successfully vaccinated being 71 per cent. (as compared with 73 per cent. in 1953 and 70 per cent. in 1952). The figures for primary immunisation against diphtheria are at first glance paradoxical: the percentage of pre-school children immunised has risen to 59 (as compared with 56 in 1953 and 51 in 1952), but the actual number of immunisations performed has declined. The explanation is that, in 1952 and 1953, a considerable number of children who had not been immunised in infancy were inoculated during their first year at school, whereas in 1954 more children were immunised in infancy and fewer were in need of primary immunisation when they attained the age of school entry. The figures for inoculation against whooping cough remained almost identical with those for the previous year.

In the report for 1953 it was noted that general practitioners were undertaking less vaccination and immunisation than in the past. This trend has continued in 1954. General practitioners performed about 41 per cent. of smallpox vaccinations in 1954 (as against 50 per cent. in 1953), 31 per cent. of primary diphtheria immunisations (as against 29 per cent. in 1953), 5 per cent. of reinforcing injections for diphtheria (as against the same figure in 1953), and 36 per cent. of inoculations against whooping cough (as compared with 40 per cent. in 1953).

At the end of the year the Health and Welfare Department secured a research grant from the Advisory Council for Medical Research, to pay in full for the cost of an investigation of the efficiency of combined immunisation against diphtheria, whooping cough, and tetanus.

(1) VACCINATION AGAINST SMALLPOX.

It is sometimes said that compulsion is an indication of national immaturity; as civilisation progresses, persuasion can often replace compulsion. Vaccination against smallpox is still as necessary as ever, or perhaps more necessary than ever, in view of the increased possibilities of infection consequent on the spread of air travel, but since 1948 compulsory vaccination has been abolished and reliance placed on the persuasive efforts of the local authority. In all clinics and also in the course of their visits to the infant's home, the health visitors impress upon each mother the necessity of having her baby vaccinated against smallpox. The actual vaccination is performed either by the child's general practitioner (who receives a standard fee for notifying vaccination to the local authority) or by doctors at child welfare clinics.

The total number of primary vaccinations in 1954 was 2,640, as compared with 2,716 in 1953 and 2,381 in 1952. During 1954, 1,091 vaccinations were notified by general practitioners and 1,549 were done at local authority clinics. The comparable figures for 1953 were 1,381 by general practitioners and 1,330 at clinics. The following table gives an analysis of primary vaccinations by year of birth and type of reaction:—

ANALYSIS OF PRIMARY VACCINATIONS.

Year of Birth	Typical Vaccinia greatest at 7th-10th day	Accelerated (Vaccinoid) Reaction 5th-7th day	Greatest Reaction 2nd-3rd day	No Local Reaction	Total
1954	1,521	7	3	121	1,652
1953	701	1	2	58	762
1952	60	...	...	...	60
1951	37	...	...	2	39
1950	26	...	...	...	26
1949	18	...	...	..	18
1948	10	...	...	...	10
1947	9	...	...	..	9
1946	5	...	...	...	5
1945	4	...	...	...	4
1944 or earlier	55	...	...	...	55
Totals	2,446	8	5	181	2,640

In the era of compulsory vaccination, about 85 per cent. of children in Aberdeen were actually successfully vaccinated; the Registrar-General's report for 1947 gives the figure of 85.1 per cent. for children born during 1946. For children born in 1953, the proportion successfully vaccinated by the end of 1954 was 71 per cent., and from the table it would appear that this figure is likely to be maintained in the case of children born during 1954.

For propaganda purposes, reliance is more and more being placed almost exclusively on the influence of the health visitors.

(2) IMMUNISATION AGAINST DIPHTHERIA.

(a) Cases of Diphtheria.

No cases of diphtheria have occurred in the City since 1952 (when there were three cases). There has been no fatal case of diphtheria in the City since 1950, in which year a non-immunised child died.

(b) Propaganda employed for Primary Immunisation.

As in the case of vaccination against smallpox, the health visitors make a great effort to ensure as far as possible that all children are immunised against diphtheria in their first year of life. This effort is not confined to the clinics but is also made in the people's homes. Leaflets are handed out and posters are displayed at the clinics, but it is felt that the personal approach by the health visitor is the thing of supreme value, to which all other measures of propaganda are merely supplementary.

(c) Re-immunisation.

Efforts are made to ensure that as many children as possible receive a reinforcing dose either just before going to school for the first time or in their first year at school, and a second reinforcing dose is available about three years later.

(d) Numbers immunised.

The numbers of individuals who completed a full course of immunisation or who received a reinforcing injection during 1954 are given in the accompanying tables. Figures for 1953, 1952, and 1951 are also provided for purposes of comparison.

DIPHTHERIA IMMUNISATION.

	Primary Immunisation				Reinforcing Dose			
	1954	1953	1952	1951	1954	1953	1952	1951
Number Immunised—								
(a) By General Practitioners	1,031	1,105	1,168	1,247	200	186	204	127
(b) At Child Welfare Clinics	1,639	1,721	1,162	1,121	166	230	137	98
(c) By School Health Service	630	970	937	812	3,614	3,768	3,600	2,987
	3,300	3,796	3,267	3,180	3,980	4,184	3,941	3,210

In other words, 31 per cent. of primary inoculations were carried out by general practitioners and 50 per cent. by doctors at child welfare clinics. Nineteen per cent. of primary inoculations were undertaken at school (about four years late), and the school health service also carries out over 90 per cent. of the reinforcing injections.

A more detailed breakdown of the immunisations performed during 1954 is given in the next table.

DIPHTHERIA IMMUNISATION.

The following tabulated statement shows the number of children immunised each year since 1945:—

Age in years on 31st December of the corresponding year.	1945	1946	1947	1948	1949	1950	1951	1952	1953	1954	Total Immunised on 31st December, 1954.
Under 1 Year	10	102	119	88	103	140	169	334	438	Aged under 5 Years 8,983
1 Year	374	323	972	1,171	1,270	1,345	1,506	1,511	1,686	1,688	
2 Years	497	438	427	268	426	671	418	351	398	253	
3 "	252	152	170	87	138	216	116	115	193	128	
4 "	155	93	118	64	50	106	79	72	130	85	
5 "	99	226	286	220	196	230	236	281	266	206	
6 "	304	419	498	382	428	438	427	563	575	355	Aged 5 Years and over 20,875
7 "	250	75	47	32	25	32	16	16	27	17	
8 "	26	54	40	22	9	15	13	6	10	6	
9 "	23	337	393	350	236	142	209	171	164	119	
10 "	20	12	28	7	4	3	4	3	4	1	
11 "	8	11	17	9	2	4	3	2	3	...	
12 "	5	9	14	16	3	3	9	2	3	1	
13 "	7	2	9	1	1	...	2	...	...	1
14 "	6	7	4	2	1	...	...	...	1	...
15 Years and over	23	18	5	9	3	3	2	5	2	2	
Total each Year Immunisations	2,049	2,186	3,130	2,759	2,880	3,311	3,180	3,267	3,796	3,300	Grand Total—1945-1954 29,858
Reinforcing Injections	895	2,740	2,785	2,998	2,855	3,189	3,210	3,941	4,184	3,980	30,777

(e) Percentage of Pre-school children who were immunised against Diphtheria at end of 1954.

The percentage of children aged 0-5 years recorded as being immunised was 51 in 1952, 56 in 1953, and 59 in 1954. While the trend is definitely in the right direction, it is highly desirable that the figure be raised to a considerable further extent. It must be emphasised that immunisation is a valuable safeguard against a dangerous disease, and that the Aberdeen figures still compare poorly with those of many other areas.

(3) IMMUNISATION AGAINST WHOOPING COUGH.

Although the Department of Health for Scotland has not yet given official approval to any vaccine as being completely efficacious, the Corporation—which carried out diphtheria immunisation for sixteen years before that form of protection was officially accredited—undertakes immunisation against whooping cough at the child welfare clinics. The health visitors encourage all mothers to have their children immunised either at the clinics or by their own general medical practitioners.

The following summary gives the numbers immunised against whooping cough during 1954:—

By general practitioners	903
At clinics	1,580
	<hr/>
Total	2,483
	<hr/>

(4) RESEARCH PROJECT—COMBINED IMMUNISATION AGAINST DIPHTHERIA, WHOOPING COUGH, AND TETANUS.

Although tetanus is not a common disease, it has a very high mortality rate when it occurs. Even so, there are in Britain about 80 deaths a year from this cause. There would undoubtedly be many more cases were it not for the universal hospital practice of giving injections of anti-tetanic serum to every patient with an open injury. This serum quite frequently gives rise to very unpleasant, though not serious, reactions. For these reasons, if some other means of preventing tetanus can be used, it is desirable that it should be introduced into the normal programme of immunisation of children. As a result of war-time and other experience, it has been proved that there is an efficient agent. Unfortunately, to immunise children separately for tetanus would increase the number of injections necessary.

As a result of work in France and elsewhere, it is known that protection against diphtheria and tetanus can be given by injecting a mixture of the two antigens without decreasing the potency of either, and has also been shown in this country and in the United States that diphtheria and whooping cough antigens can similarly be used together. A preparation of all three has proved effective in the laboratory and, to assess clinical efficiency, the Advisory Council for Medical Research has made available funds for a survey which is being carried out in Edinburgh and Aberdeen. The research grant pays in Aberdeen for the half-time services of a

research medical officer, the full-time services of a research health visitor, and the half-time services of a clerk.

Work began in November, 1954, and will, of necessity, last for a considerable time involving, as it must, comparison between two large groups of children. So far, the response by parents has been extremely good, although a course of five injections is necessary for all in one group, the control group, in which three injections are given against whooping cough alone, and the other two against diphtheria and tetanus combined. In the trial group, only three injections (of mixed whooping cough, diphtheria, and tetanus antigens) are required. When inoculations have been completed each child will be visited at monthly intervals to find out any infection or contact with whooping cough as well as other control infections. A final statistical analysis will embrace all information from Edinburgh and Aberdeen.

(5) IMMUNISATION AGAINST TUBERCULOSIS.

(a) *Immunisation of Contacts.*

Immunisation of contacts is carried out under the direction of the Chest Physician at the City Hospital, although a small amount of skin testing is carried out at child welfare clinics.

(b) *Immunisation of School Children.*

In 1953, the Corporation decided to carry out tuberculin testing and B.C.G. immunisation of school leavers and particulars of the work done were recorded in the "School Health Service" section of the report for that year. The Department of Health for Scotland have now recommended to all local authorities that they should make provision for similar services in their areas.

During 1954, B.C.G. immunisation was offered to all children aged 13 years and upwards. However, as a matter of administrative convenience, the campaign (which, in 1953, was carried out during the summer) was switched to the autumn and winter. Details will be provided in the School Health Services Report for 1954-55. A brief summary is given in the section of this report dealing with Prevention, Care, and After-care.

(6) OTHER IMMUNISATIONS.

Persons going abroad to certain countries need to be immunised against such diseases as yellow fever, &c., and this immunisation is normally carried out at the City Hospital.

10.—PREVENTION OF ILLNESS, CARE, AND AFTER-CARE.

The Corporation's scheme was altered in 1953 to permit of future developments. Some of the developments in 1954 were—appointment of an assistant nurse to work in the tuberculosis clinic, thereby affording the health visitors a greater measure of time for home visiting; extension of the chiropody service; considerable progress with the register of elderly persons and the provision of health care for the elderly; and—by no means least—a full-scale home safety campaign.

In respect of tuberculosis, it may also be appropriate to mention that the death-rate fell from the 1953 low record of 0·16 per thousand population to 0·12 per thousand.

(A) TUBERCULOSIS.

(a) General.

Responsibility in this disease is divided (since 1948). The broad division of responsibility is that the provision of institutional care and specialist services are the concern of the Regional Hospital Board, while all functions relating to prevention, care, and after-care are in the hands of the local authority. Some of the latter functions may be briefly outlined—

(i) Contact tracing and follow-up. A patient may be notified by a general practitioner but is more usually notified by a chest consultant to whom the patient has been referred by the practitioner. Immediately a case is notified, the health visitor for the particular area visits the home and ascertains the number of persons in the house, sleeping accommodation, family medical history, &c.; and endeavours are made to have all members of the household radiologically examined at the City Hospital. This follow-up of all cases is of greatest value and may be the means of other members of the household keeping clear of the disease. It is also of profound epidemiological importance; tuberculosis is spread principally by unsuspected, undiagnosed persons.

(ii) Co-operating with the Regional Hospital Board and with general practitioners in determining the need of patients for admission to hospital. The Senior Chest Physician acts in respect of preventive work as an honorary member of the staff of the department, with six health visitors seconded to him. He, therefore, has at his disposal his own clinical record, a comprehensive report submitted by the health visitor on home circumstances, and any information made available to him by general practitioners. Hence he is in a very strong position to make a sound decision about the relative need for the admission of different patients to hospital.

(iii) Assisting households with a tuberculous member to obtain adequate accommodation. The Corporation, some time ago, adopted a policy whereby tenancy of Council houses is, in appropriate cases, granted to persons suffering from "open" tuberculosis, so that segregation of the infectious case can be made. It will, however, be appreciated that, with over 200 cases of tuberculosis notified annually, it is not practicable to allot houses to all tuberculous patients.

(iv) Advice offered by health visitors to persons suffering from tuberculosis and living at home. This advice covers the proper segregation of the patient from the rest of the household and the precautions which should be taken with a view to improving environmental hygiene, maintaining general health, increasing resistance, and generally ensuring that the remainder of the household do not contract tuberculosis.

(v) Arranging, where necessary, for boarding-out of child contacts. Under the Corporation's Proposals for the Discharge of Functions, arrangements are made whereby child contacts can be sent to Linn Moor Home, Culter, a convalescent home run by a voluntary organisation. The Corporation, of course, make a payment in respect of the boarding-out of such child contacts. The period of residence in Linn Moor Home varies according to the health of the child. In 1953, the Corporation amended their Proposals for the Discharge of Functions so that they are now empowered to send to Linn Moor Home any child who is debilitated, and are no longer restricted to the contacts of tuberculous patients.

(vi) Providing beds, bedding, and nursing requisites. In certain circumstances, a loan is given of beds and bedding, on the recommendation of the Chest Physician after the health visitor has submitted a report on the home conditions.

(vii) Co-operating with Ministry of Labour in resettlement of tuberculous persons in employment or in their entry to sheltered employment. With regard to the resettlement of tuberculous persons, the Chest Physician is in close contact with the Ministry of Labour and National Service to ensure that patients who have suffered from tuberculosis obtain employment suitable to their condition. The Corporation also send patients to Papworth Village Settlement and to the British Legion Village at Preston Hall, where tuberculous patients unfit for their previous occupation may obtain training in other occupations. At the end of the year there were two persons resident in Papworth Village Settlement for whom the Corporation were making a contribution towards maintenance.

There is as yet no voluntary after-care committee for tuberculosis in the City.

(b) Co-ordination with diagnostic and curative service.

By arrangement with the Regional Hospital Board, the Senior Chest Physician and his staff are available for the medical supervision, under the administrative control of the Medical Officer of Health, of the operation of the Corporation's arrangements. When discharging functions under these arrangements, the physician is regarded as having the status and responsibilities of a Deputy Medical Officer of Health (Tuberculosis); and—as indicated above—a number of health visitors are employed full-time on tuberculosis work and operate under the direction of the Chest Physician.

Co-ordination is facilitated by the fact that the Chest Physician has himself had considerable experience of local authority work and by the fact that the tuberculosis health visitors undertake the duties which in some other areas are discharged by almoners. In practice, co-ordination is extremely good. When a case of tuberculosis is notified to the Medical Officer of Health by a general practitioner, the

notification is forthwith intimated to the Chest Physician and, where a suspected case is referred by the practitioner to the Chest Physician, the notification is made by that officer whenever diagnosis is complete. Moreover, where deemed desirable, action can be taken in advance of any formal notification. A sanitary inspector's report and a health visitor's report are made available so that the Chest Physician has full information on clinical state, family circumstances, housing conditions, &c. In the light of the full information, the Chest Physician is enabled to reach decisions about the patient's admission to hospital. Contacts, as already mentioned, are followed up by local authority health visitors and urged to attend for examination by the Chest Physician, and health visitors advise patients about hygienic aspects when living at home, about allowances, and help available. When discharge of a patient from hospital is contemplated, the Medical Officer of Health is notified of any particular needs. Indeed, the complete co-ordination and co-operation that exists in respect of tuberculosis might well serve as a model for the setting up of schemes for other diseases.

(c) Examination of contacts.

The patient's family or household are regarded as a unit and, as already stated, an endeavour is made to have all members of the family radiologically examined at the City Hospital. Considerable persistence and persuasive skill on the part of the health visitor are sometimes necessary to gain the full co-operation of the family, but it is interesting to note that, during the year under review, 1,459 contacts were examined. The number of contacts who, during the year, were clinically examined, skin tested, and found to have tuberculosis was 31.

(d) B.C.G. Vaccination.

The following is a copy of the return which was submitted to the Department of Health, giving particulars of the B.C.G. vaccinations performed:—

B.C.G. VACCINATION, 1954.

RETURN FOR PERIOD 1ST JANUARY, 1954 TO 31ST DECEMBER, 1954.

GROUP	Tuberculin Tested		Negative Re-actors		Vaccinated during 1954	
	M.	F.	M.	F.	M.	F.
(1) Nurses	15	250	—	76	—	75
(2) Medical Students	64	21	17	8	16	6
(3) Contacts	268	298	239	256	201	227
(4) Special Groups not included in (1) to (3) above:— School leavers	2,424	2,470	1,574	1,651	1,548	1,609
(5) Others	38	56	20	22	14	6

(e) Mass Miniature Radiography.

The mass miniature radiography unit of the Regional Hospital Board commenced large-scale operations during 1953 and, during that year, a total of 31,687 persons were x-rayed. Of that number, 92, or 0·3 per cent., were found to be suffering from tuberculosis. In 1954, the unit was away from Aberdeen for a considerable portion of the year. During the months in which it was in the City, 19,073 persons were examined, of whom 42, or 0·2 per cent., were found to be suffering from tuberculosis.

(f) Supply of extra nourishment.

Extra nourishment (such as cod liver oil and milk) is given to necessitous cases on the recommendation of the Chest Physician. It is interesting to note that, during the year, 424 patients received milk free of charge at a cost to the Corporation of approximately £2,296.

(g) Notification.

Table A gives the number of tuberculous cases notified during 1954 and, for comparative purposes, the figures for 1953 and 1952 are also given. These are divided into respiratory and non-respiratory and arranged according to age-period and sex.

CITY OF ABERDEEN.

CASES AND DEATHS FROM RESPIRATORY TUBERCULOSIS, 1940-1954

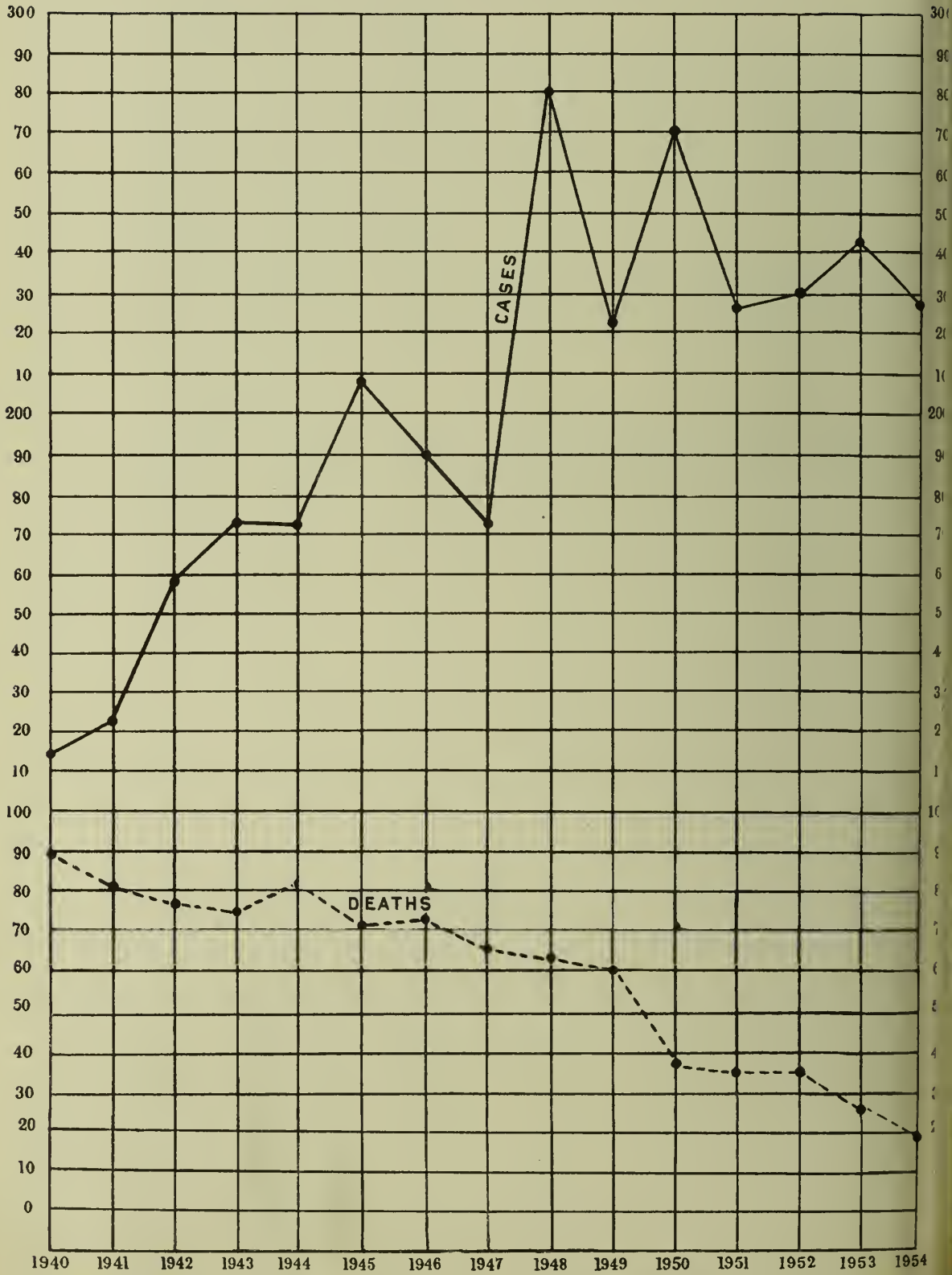


TABLE A.—NUMBER OF CASES OF TUBERCULOSIS NOTIFIED IN 1954.

	NUMBER OF CASES NOTIFIED AS SUFFERING FROM TUBERCULOSIS.								
	AGE-GROUPS.								
	Under 1	1-5.	5-15.	15-25.	25-35.	35-45.	45-65.	65 upwards.	TOTAL.
RESPIRATORY.									
1954 Males	2	7	3	8	23	20	54	6	123
1953 Males	—	7	8	35	20	19	30	8	127
1952 Males	1	5	14	16	18	15	37	5	111
1954 Females	1	6	5	6	48	22	15	2	105
1953 Females	—	4	15	46	32	11	7	1	116
1952 Females	1	3	12	55	17	19	10	2	119
NON-RESPIRATORY.									
1954 Males	1	3	—	2	2	—	2	—	10
1953 Males	—	4	1	1	—	1	2	1	10
1952 Males	—	1	3	2	5	1	1	1	14
1954 Females	—	3	2	3	3	3	1	1	16
1953 Females	—	5	3	3	4	—	6	—	21
1952 Females	—	1	2	5	5	1	2	—	16
RESPIRATORY AND NON RESPIRATORY.									
1954 Male and Female	4	19	10	19	76	45	72	9	254
1953 Male and Female	—	20	27	85	56	31	45	10	274
1952 Male and Female	2	10	31	78	45	36	50	8	260

The appended graph shows the notifications and deaths from respiratory tuberculosis during the past few years.

As regards the site of the disease, in the 26 cases notified as suffering from tuberculosis other than respiratory, 3 suffered from tuberculosis of the bones and joints (including spinal tuberculosis), 5 from tuberculous meningitis, 9 from tuberculous glands, 4 from genito-urinary tuberculosis, 3 from abdominal tuberculosis, and 2 from other forms of tuberculosis.

Of the 228 notified cases of respiratory tuberculosis, 211 were confirmed, and of the 26 non-respiratory cases, all were confirmed.

The number of persons residing in Aberdeen who, at 31st December, 1954, were known to be suffering from tuberculosis was 1,746—1,655 respiratory and 91 non-respiratory cases.

Table B gives particulars of those who died during 1954, detailing the period which elapsed between notification and death.

**B.—NUMBER OF PERSONS WHO DIED FROM TUBERCULOSIS IN ABERDEEN, WITH
PARTICULARS AS TO PERIOD ELAPSING BETWEEN NOTIFICATION AND DEATH—
YEAR, 1954.**

	RESPIRATORY.		NON-RESPIRATORY.	
	Males.	Females.	Males.	Females.
Number of Persons who died from Tuberculosis	* 15 (17)	* 4 (9)	* 1 (3)	* 3 (1)
of whom—				
Not notified or notified only at or after death	1 (—)	— (—)	1 (2)	1 (—)
Notified less than 1 month before death	1 (2)	— (2)	— (1)	1 (1)
„ from 1 to 3 months	— (—)	— (—)	— (—)	— (—)
„ „ 3 to 6 „	— (—)	— (—)	— (—)	— (—)
„ „ 6 to 12 „	— (2)	— (1)	— (—)	— (—)
„ „ 1 to 2 years	1 (1)	— (—)	— (—)	1 (—)
„ over 2 years	12 (12)	4 (6)	— (—)	— (—)
TOTAL	15 (17)	4 (9)	1 (3)	3 (1)

* 1953 figures in brackets.

Here are the total deaths from that disease in recent years:—

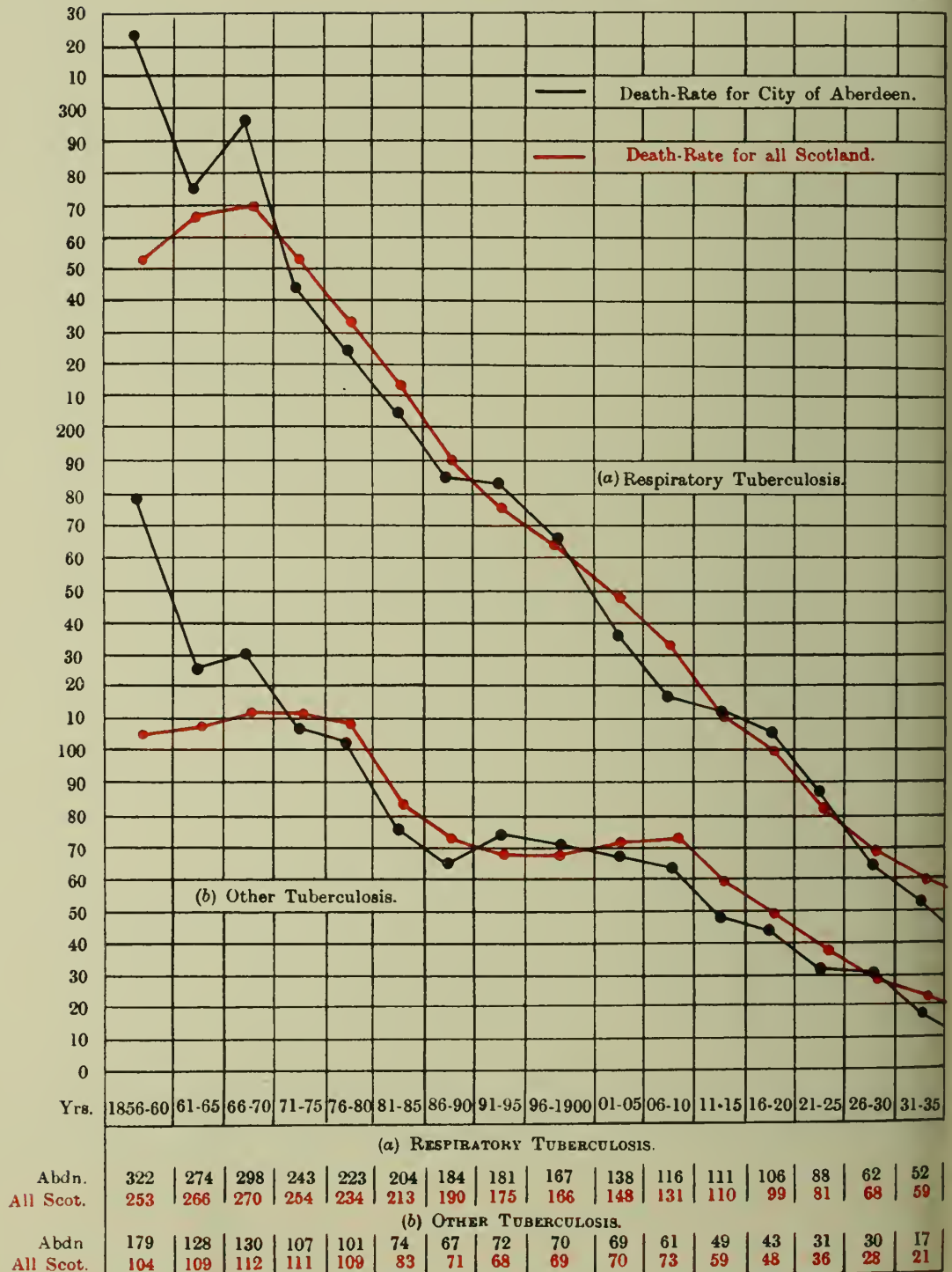
	1949.	1950.	1951.	1952.	1953.	1954.
Respiratory	60	38	36	36	26	19
Non-Respiratory	6	5	5	4	4	4

The death-rates per 1,000 of population from tuberculosis in Scotland and in the four large cities for the years 1954, 1953, and 1952 are given in the following table:—

	1954			1953			1952		
	Total	Resp.	Other	Total	Resp	Other	Total	Resp.	Other
All Scotland	0·22	0·20	0·02	0·26	0·23	0·03	0·32	0·27	0·04
Glasgow	0·37	0·34	0·03	0·47	0·43	0·04	0·59	0·53	0·06
Edinburgh	0·20	0·19	0·01	0·25	0·23	0·02	0·30	0·26	0·04
Dundee	0·20	0·19	0·01	0·20	0·17	0·03	0·25	0·22	0·03
Aberdeen	0·12	0·10	0·02	0·16	0·14	0·02	0·22	0·20	0·02

The accompanying chart shows the death-rates since 1856, together with a comparison between Aberdeen and all Scotland.

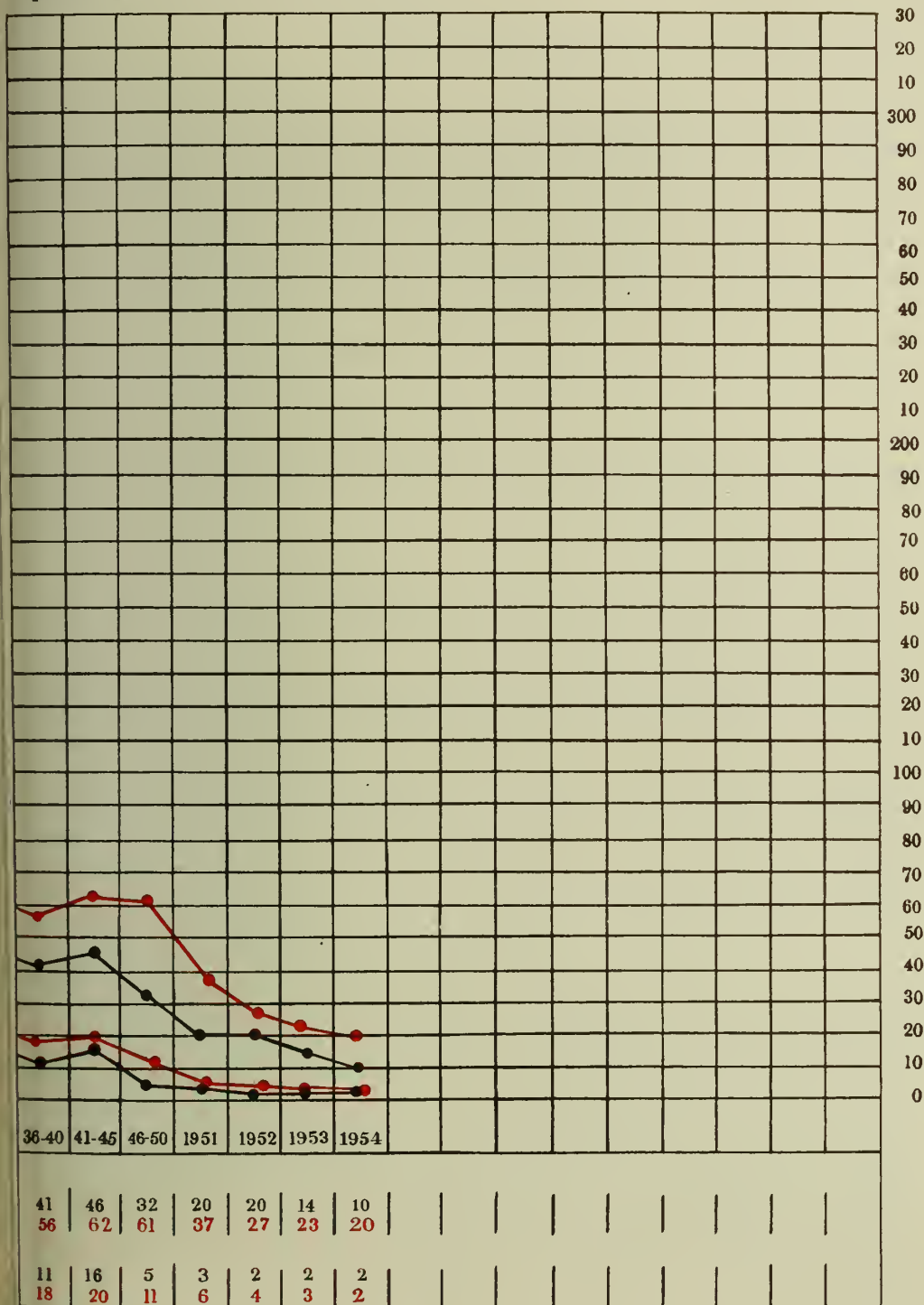
Deaths per 100,000 of Population. (Civilian)



(Corrected for transferred deaths in 1904 and subsequent years.)

BOTH SEXES.

Population and Civilian Deaths 1940-1946.)





(B) OTHER DISEASES.

Prevention—General Points.

(1) The measures employed for the specific prevention of diphtheria, whooping cough, tetanus, and smallpox have already been described in the section of the report dealing with vaccination and immunisation.

(2) General measures for the prevention of diseases in children have been outlined in the section on maternity and child welfare.

(3) Health education, including the important aspect of the promotion of mental health, is discussed in a subsequent section.

(4) A home safety campaign—the first in the country—is also discussed in the section on Health Education.

Prevention of diseases in the elderly.

Since prevention, after-care, and welfare are closely linked in the case of old people, it is convenient to discuss the measures for the health and welfare of the elderly in a subsequent section. However, it may be appropriate to mention two points here:—

(a) Following the decision at the end of 1953 to compile a register of elderly persons and elderly couples living alone, over 800 such people were intimated to the Health and Welfare Department. All were visited by health visitors and asked whether they wished to have such visits and any other help deemed necessary: over 99 per cent. indicated a desire for the visits. Those accepting had full particulars recorded, their needs were assessed, and an effort was made to supply any needs that appeared to be unmet.

(b) The chiropody service, inaugurated in July, 1952, has developed considerably during 1953 and 1954. Sessions are now held at Castlegate Clinic on Mondays and Tuesdays, 9 a.m. to 12.30 p.m. and 2 p.m. to 5 p.m., and Thursdays and Fridays from 9 a.m. to 12.30 p.m. During the year to 31st December, 371 persons received treatment and 1,939 visits were paid by those persons. One hundred and thirty-nine cases were treated in their own homes, necessitating 650 visits. The service has proved of immense value to the elderly.

Care and After-Care.

The work of the local health authority has here again been very greatly extended by the National Health Service (Scotland) Act, but, as in so many other fields of the work, shortage of staff has as yet prevented the full implementation of the new duties.

Apart from care and after-care in cases of tuberculosis, it may be relevant to mention here the care services that are being developed for the elderly. District nurses are asked to refer to the Health and Welfare Department any elderly patients whom they have been attending and are ceasing to attend and who, in their opinion, would benefit from visits by health visitors. Similarly, hospital

staffs have been asked to refer elderly patients who are being discharged from hospital and who might benefit from such visits. This scheme of after-care for the elderly is still only in process of development but, already, it is apparent that it will have the double advantage of reducing the need for hospital beds and of keeping active and happy in their own homes many old people who otherwise would become bedfast and incapable of leading an independent existence.

Incidentally, the prevention and after-care services for old people are already reducing the anticipated need for hostel accommodation.

11.—HEALTH EDUCATION.

Some developments during 1954 were—(1) the organisation of a post-qualification course in mental health to enable health visitors more adequately to undertake their important duties in respect of mental health education; (2) the holding of a study day on the health care of the elderly, to make health visitors more fully aware of the tasks confronting them in respect of the health education of persons of ripe years; (3) the holding of a study session for departmental medical officers on the same subject; and (4) a full-scale campaign—the first in the country—for the prevention of home accidents. The first two of these developments are mentioned more fully in the section of the report entitled *Training of Health Visitors*.

The Need for Health Education.

Health education is by far the most important function of a local health authority, and its relative importance is increasing year by year.

In the past, many improvements in the health of the community could be brought about by measures imposed by the local authority without the need for active co-operation by individual citizens; the reduction of water-borne diseases by the provision of safe water supplies and proper sewerage systems is a case in point. Increasingly, however, further improvements in health are coming to depend on the activity of the citizens as a whole. This is true of some of the remaining infectious diseases; we cannot hope, for instance, to eradicate food-borne infections without the active co-operation of the persons who handle food in the shop and in the home. It is even more true of non-infectious physical conditions; for example, we cannot do much to prevent domestic accidents unless the average householder is persuaded to pay some attention to home safety. It is also true of diseases of mental and emotional origin: to lessen neurotic conditions by improving the standards of parent-craft and child-care the interested and active co-operation of parents is an obvious necessity. Moreover, health is something more than simply the absence of disease. Health is, in fact, a condition of physical, mental, emotional, social, and spiritual well-being, a state in which body and mind are functioning efficiently, and in which the individual is correctly adjusted to all factors in his environment. The promotion of health can be achieved only by health education.

Varieties of Health Education.

Probably the commonest misconceptions about health education are that it is simple and that it consists mainly of group-teaching. The misconception about simplicity is due to the early emphasis on the simple things necessary to prevent food-borne infections—hand-washing, physical cleanliness, &c. Actually, if one considers such aspects of health teaching as the rectification of the attitude of a mother who is over-protecting a delicate child or who is expecting from her three-year-old the behaviour standards of a child of four, or the convincing of a man previously engrossed with his work that he ought to cultivate hobbies in preparation for his retirement, it soon becomes obvious that health education (far from being simple) is about the most complex subject in the whole range of the medical and biological sciences.

As for group-teaching, while it is a valuable adjunct to individual health-teaching, it cannot as a rule be more than a supplement. Health Weeks, Health Sundays, Health Exhibitions, public lectures, and so forth are really useful only when employed to reinforce the work of the individual health teacher in the home.

Individual Health Teaching.

The education of individual persons and individual families in their own homes is the primary task of the district health visitor, supplemented by other health workers. It is of basic importance, because the health visitor knows the personality, temperament, interests, abilities, and social and educational background of the individual, and can adapt her teaching to the particular needs and capacities of the person taught.

Individual health teaching comprises a large part of the work of health visitors and departmental medical officers. The family health visitor in the home advising on the immunisation of the baby or the behaviour difficulties of the toddler or the preparation for retirement by the elderly persons, the health visitor guiding the family as a whole towards a better integration with their environment (in the wider sense of that word), the doctor at the child welfare clinic advising an individual mother about the physical or emotional problems of her child, the doctor at the ante-natal clinic discussing with an expectant mother the hygiene of pregnancy, the health visitor at the same clinic discussing the emotional re-adjustments that will be necessitated by the birth of the child, the school doctor or school health visitor inculcating the idea of health maintenance as part of one's duty to oneself and to the community, the district nurse or the sanitary inspector or the home help striving in the case of an individual household to remove factors prejudicial to health—these are the various people who do most of the effective health education teaching. The family health visitor has, inevitably, the main role: she has considerably more training in health teaching than has the departmental medical officer, and she has the tremendous advantage of free access to the homes.

In Aberdeen, the vital role of the family health visitor in health teaching has been recognised: the establishment has been increased to 85 health visitors (or 1 per 2,200 total population), and efforts are being made to secure, over a series of

years, the necessary staff to fill the vacancies. The existing district health visitors are already undertaking a considerable amount of individual health education and efforts are being made—by study days, &c.—to equip them more fully for these tasks.

For the most complicated but also the most needed form of individual health teaching, education in mental health, it has been appreciated in Aberdeen that the health visitor not only possesses unique qualifications—an unrivalled knowledge of normality, a training in the art of persuading, an entry to the home before any faulty situation exists, an intimate knowledge of the family, and, in the eyes of the family, the authority conferred by her triple training as nurse and midwife and health visitor—but is about the only person in the community who is at all competent to undertake this teaching. Accordingly, the better to enable health visitors to cope with the teaching of mental health, a post-qualification course in that subject was conducted in 1954 and it is hoped to have a similar course in 1955. It may be mentioned, however, that the finding of suitable lecturers to take part in such a course constitutes a very real difficulty.

Group Health Education.

Although generally unsatisfactory by itself, group health education can form a most useful supplement to individual teaching in the home or at the clinic. Some of the avenues open include systematic series of discussions or talks with adults (*e.g.*, at parents' clubs or ante-natal clinics), systematic health teaching in schools, occasional or sporadic talks at Youth Clubs or Community Centres, organisation of district health exhibitions, formal public lectures, and the use of press advertisements, posters, &c. Some local health authorities have already set up health education sections of their health departments and have already made quite a feature of group teaching.

While Aberdeen has not yet reached the stage of having a fully developed health education section of the Health and Welfare Department, certain tentative beginnings had been made before 1954. For example—a little group teaching was undertaken at some ante-natal and child welfare clinics; a number of members of the medical and health visiting staff devoted many evenings to addressing clubs and societies on health matters; and press advertisements and posters were utilised in various diphtheria immunisation campaigns and in the highly successful tuberculosis immunisation campaign of 1953. In 1954, there was some extension of health teaching at clinics, the number of evening talks given by members of the staff increased, the tuberculosis immunisation campaign was repeated, and—a major new development—a full scale campaign was conducted for the prevention of home accidents.

The biggest task confronting the Health and Welfare Department in the immediate future is the adequate development of a health education service.

THE HOME SAFETY CAMPAIGN.

Aberdeen had the honour of being the first place to conduct a full-scale campaign for the reduction of home accidents, Stirlingshire and London (although also conducting campaigns in 1954) being about six months after Aberdeen.

The need for a campaign.

In Aberdeen in 1953, out of nineteen deaths of children aged 1-5 years, no fewer than 7 were ascribed to violence (and only one of these seven was the result of a road accident); and of 15 school children who died, 2 deaths were ascribed to home accidents. In Scotland, it has been calculated that about 50,000 patients suffering from domestic accidents are admitted to hospital annually, while about 500,000 persons receive treatment in their own homes. In Britain, there were in 1952, four fatal home accidents for every three road deaths, the actual numbers being 6,419 and 4,706, respectively.

The cost of home accidents in terms of hospital expenditure, loss of working time, and so forth is enormous, but (as one of the organisers of the campaign expressed it in a published article) "Quite immeasurable but certainly not less important is the cost in terms of needless human suffering; the grief of the bereaved parent, wise too late; the distress of the toddler suddenly removed to the strange and frightening world of hospital; the anguish of the adolescent doomed to permanent crippling or disfigurement."

While more research work and skill is undoubtedly needed into the epidemiology of home accidents (*e.g.*, direct and predisposing causes, relationship with fatigue, and other environmental factors, &c.), it was felt by officers of the Health and Welfare Department in 1953 that sufficient information already existed to permit of a substantial reduction of domestic accidents by the same health education techniques as had in the past contributed so largely to the eradication of infectious and nutritional diseases in this country.

Basic Plan.

It was felt that the first necessity was to make the people as a whole aware of the fact that home accidents were a major cause of death and disability, after which the health visitors and other health workers could—with more hope of response—draw attention to potential causes of accidents in individual homes.

The Home Safety Campaign, which was planned in the autumn of 1953 and the central portion of which took place in May, 1954, may therefore be conceived as having three facets—(a) the creation of a climate of public opinion in which individual accident prevention work would have some hope of success; (b) individual work in the homes of the people; and (c) the maintenance of that favourable climate of public opinion.

Planning the Initial Campaign.

To create a favourable climate of public opinion it was essential to have a centre-piece to the campaign and to obtain very adequate press publicity. It was decided to hold three public meetings in a large hall, the first meeting dealing primarily with accidents in children, the second with accidents in the elderly, and the third with the role of the health worker in the prevention of accidents. Mrs. W. E. Duncan, Manager of the Home Safety Section of the Royal Society for the Prevention of Accidents, very kindly undertook to visit Aberdeen for the Home Safety Week

and to act as the principal speaker at the main meetings. It was arranged that the Deputy Medical Officer of Health would act as the subsidiary speaker at one of the meetings, that a University Lecturer in Social Medicine would perform the same function at the second meeting, and that a University Lecturer in Diseases of Children would undertake the same duty at the third meeting. It was further arranged that the Chairman of the Health and Welfare Committee, the Professor of Child Health at the University, and the Lord Provost would act as Chairman at the respective main meetings.

In order to ensure an audience of satisfactory size, it was decided that individual invitations should be issued to each health visitor, medical officer, district nurse, midwife, and sanitary inspector in the City for all three meetings; that, for the first meeting, invitations should also be issued to the staffs of Day and Residential Nurseries, to the staff of the Children's Hospital, and to school teachers; that home helps, staffs of municipal and voluntary old people's homes, and the staff of the geriatric hospitals should be invited to the second meeting; and that general practitioners and senior medical students should be invited to the third meeting.

Subsidiary Meetings.

To supplement the main meetings it was arranged that talks illustrated by film strips should be provided during the week at all clinics; that every senior secondary and junior secondary school in the City should be given the opportunity of having talks on home accidents during the week; and that letters should be sent to societies and clubs offering speakers during the week. In addition, it was decided to write to every minister of every denomination asking him to draw the attention of his congregation to the Home Safety Campaign. Further, it was explained to all health visitors that they, during the week, should conduct their own private drive against home accidents. Letters were also devised for large firms.

Publicity.

Arrangements were made for the printing of a sufficiency of posters, for the purchase of other posters from the Royal Society for the Prevention of Accidents, for the printing of coloured flashes bearing appropriate rhyming slogans, and for the distribution of posters, flashes, &c.

Detailed Organisation.

After the initial plans had been worked out, a special team was formed to deal with the very heavy task of organising the campaign, although, at a later stage, some duties were delegated to other members of the Health and Welfare Department. The team comprised the Medical Officer of Health, his wife (as a voluntary and unpaid member of the team, although, since the work was very largely conducted outside office hours, the whole team could be termed unpaid), the two health visitor tutors, and a senior clerk. All the letters (well over a thousand in number) were individually signed and—to achieve maximum effect—all the campaign material as it was got ready was stored in a single room and all letters, posters, leaflets, &c. issued on a date exactly two weeks before the start of the campaign.

Types of Letters.

It was obvious right at the beginning that to duplicate a small number of letters and to try to make each letter function for different categories of people would be wholly unsatisfactory. The letters had to be carefully worded to arouse the enthusiasm wherever possible of each organisation approached. For example, letters to general practitioners emphasised the role that they could play in the prevention of home accidents in addition to asking the practitioners to display small posters about poisons in their surgeries; letters to health visitors reminded them of their golden opportunities to prevent home accidents when visiting the homes both of the young and of the old; and letters to head teachers stressed the unfortunate effects that accidents often had on the education of the children.

Press Publicity.

In addition to lavish displays of posters, flashes, &c., and in addition to the measures already mentioned, double column advertisements were inserted in local morning and evening papers for several days before and during the campaign and every effort was made to keep the Press informed about the campaign. The newspapers, aware of their responsibility to the community, and thoroughly interested in the project, responded magnificently. For example, the "Aberdeen Press & Journal" on the Saturday before the campaign started, published an article on the Prevention of Home Accidents, spread across the upper portion of four columns on the main page, printed a press statement by the Lord Provost on the Monday, and thereafter gave accounts of at least two meetings on each subsequent day. The "Evening Express" and the "Weekly Bon-Accord" also devoted much space to the project.

Rhyming Slogans.

The feature of the campaign which appeared to attract the greatest amount of attention was the use of coloured flashes each bearing a two-lined rhyming slogan. For instance, the rhyme—

Toys on stairs and dismal lighting
Cause more broken bones than fighting

was displayed in scarlet letters on a yellow background in the windows of several hundred food shops. Other flashes were exhibited on trams and buses.

Attendances at Meetings.

Each of the three principal meetings attracted audiences of about 250. In addition, 19 subsidiary meetings were addressed. What with the generous press co-operation, the rhyming flashes, the displays of posters, and the various meetings, it can safely be said that no person in Aberdeen remained unaware of the dangers of home accidents at the end of the week.

Cost.

The cost of the Home Safety Week amounted only to £208 or rather less than $\frac{1}{4}$ d. per head of population. "The cost in fact was less than the cost of three patients each spending a month in hospital at a weekly cost of £16."

Follow-up.

Throughout the ensuing months, the health visitors continued to draw attention to potential causes of accidents in individual homes. This is, of course, the facet of the campaign most likely to be productive of results but the publicity of the Home Safety Week was essential to produce a climate of opinion in which the public as a whole would respond favourably to the indication of potential causes of accidents.

Further Action.

To help to maintain the climate of public opinion favourable to accident prevention, arrangements have been made for the publication in 1955 of an illustrated book dealing with the prevention of home accidents. This book is being produced at no cost to the Corporation, the publishing firm concerned recouping itself for the cost by advertisements appearing in the book.

Effects of the Campaign.

While it is too early at the beginning of 1955 to assess in detail the results of a campaign that had its public beginning in May, 1954, the reduction in deaths from violence (mentioned in the section of this report dealing with vital statistics) at least suggests that the campaign has not been unsuccessful.

Acknowledgment.

For the information of other areas contemplating a similar campaign, a detailed account of the Aberdeen campaign appeared over the signature of Miss D. J. Lamont (Principal Health Visitor Tutor) in the "Nursing Times" of 31st July, 1954. Many of the points in the above brief description are summarised from that account.

12.—CONTROL OF INFECTIOUS DISEASES.

Features of the year included—a decrease in cases of puerperal fever and pyrexia (from 39 in 1953 to 12 in 1954); a decrease in cases of infective jaundice (from 13 to 2); a further decrease in cases of scarlet fever; a continuation of the absence of diphtheria; a further increase in dysentery (from 110 to 129); and an increase in poliomyelitis (from 12 to 34).

Cerebro-Spinal Fever.

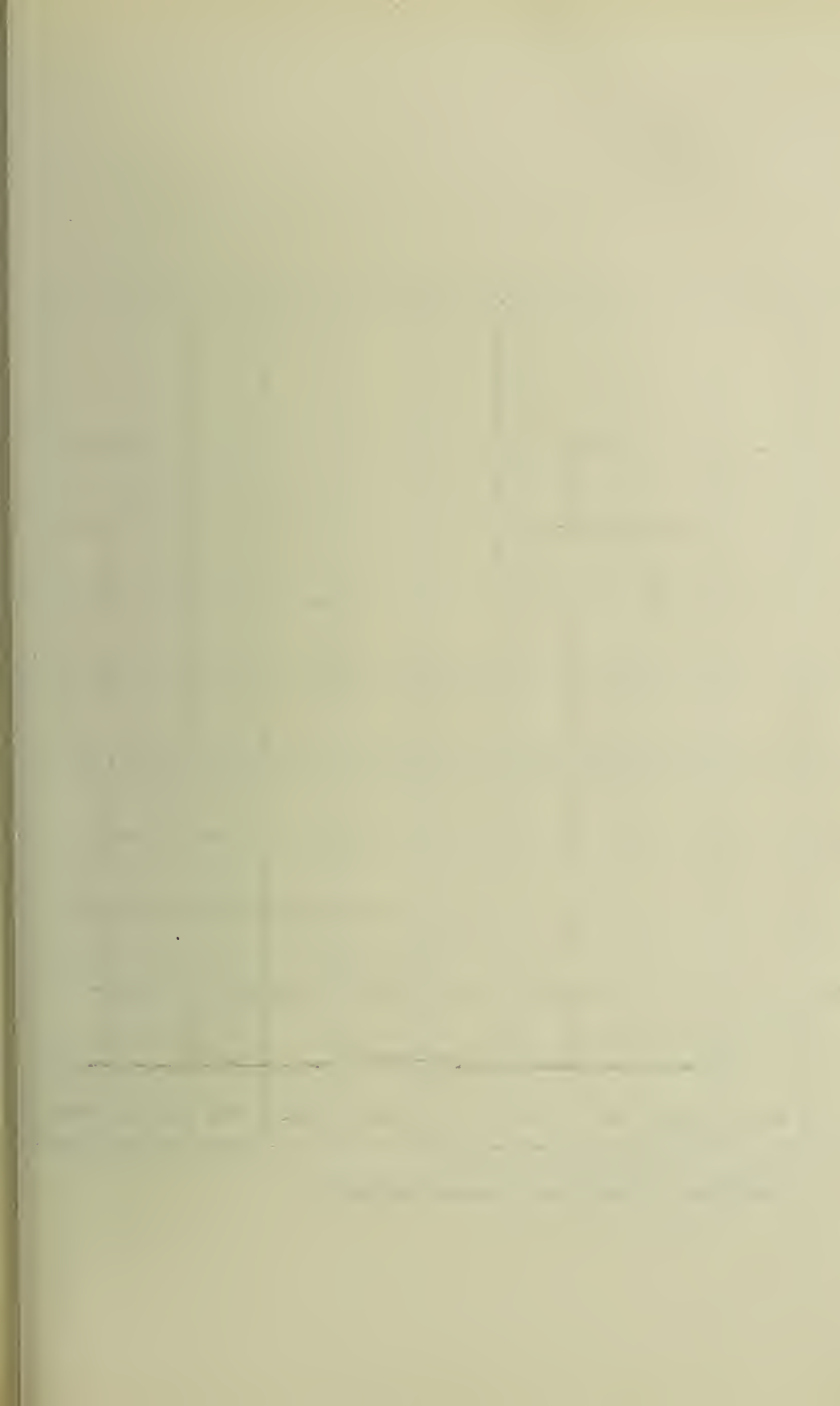
Eight cases were notified in 1954, as compared with 10 in 1953, 7 in 1952, and 24 in 1951. One of the eight cases was fatal.

Chickenpox.

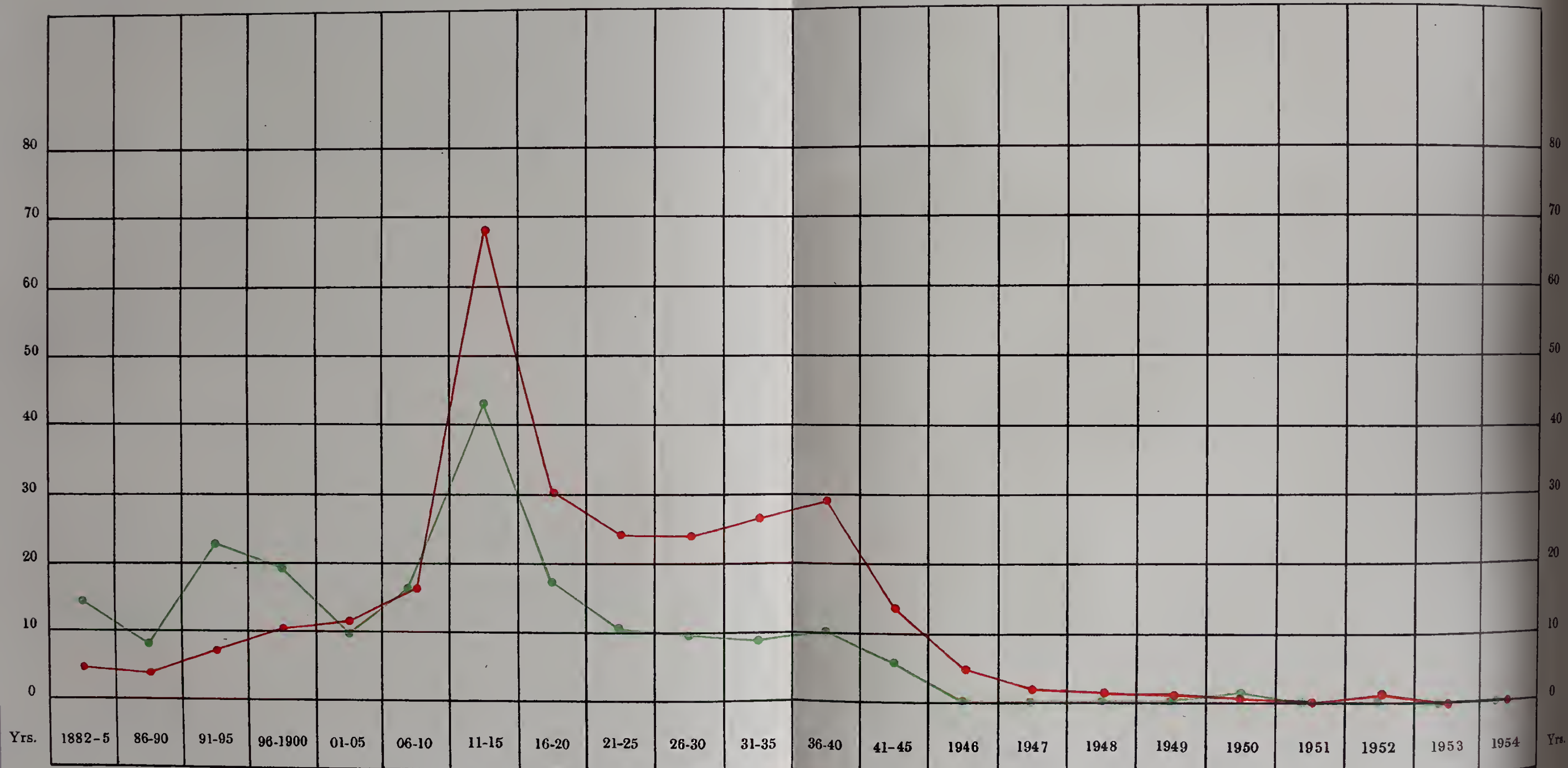
In 1954, eleven cases were brought to the knowledge of the department. As this disease is not compulsorily notifiable, the number of cases intimated offers no real indication of the prevalence of chickenpox in the City.

Continued Fever (Undulant).

Two cases were notified during the year,



ABERDEEN



DIPHTHERIA— { Attack Incidence per 10,000 of population
Deaths per 100,000 of population } 1882 - 1954 : QUINQUENNIAL AVERAGES to 1945.

Diphtheria.

In 1951, a record was established: for the first time there were no confirmed cases during an entire year. In 1952, there were three cases; in 1953, there were no cases, and it is gratifying to be able to report that there were again no cases during 1954.

With the exception of one death in 1950, in a non-immunised child of seventeen months, there have been no deaths since 1945.

It may be of interest to set out the cases and deaths in four-yearly periods:—

	Cases.	Deaths.
1951-1954 . . .	3	0
1947-1950 . . .	18	1
1943-1946 . . .	513	19
1939-1942 . . .	1,761	77

The tremendous year by year reduction from 586 cases and 21 deaths in 1940 to the figures of to-day bear eloquent witness to the efficacy of diphtheria immunisation (which began on a nation-wide scale in 1941 although employed to a limited extent in Aberdeen before that year). Details about immunisation are recorded elsewhere in this report.

The accompanying chart gives the attack incidence and death-rate from 1882.

Dysentery.

In 1954, there were 129 notified cases of this disease as compared with 110 in 1953, and an annual average of 111 in the decennium 1944-1953.

Encephalitis Lethargica.

No cases were notified during 1954.

Erysipelas.

There were 33 cases of erysipelas in 1954 as compared with 27 in 1953, 32 in 1952, and an annual average of 53 in the preceding decennium.

Infective Jaundice.

During the year there were two confirmed cases of infective jaundice. One was a worker in a slaughterhouse and the other was associated with the handling of fish boxes; neither case proved fatal.

Leprosy.

This disease has been compulsorily notifiable since 1st September, 1951. No case has been reported in this area.

Malaria.

One case was notified in 1954 as compared with 6 in 1953 and 2 in 1952.

Measles.

Compulsory notification of this disease in Aberdeen was, after a very short trial, discontinued in 1903 and has not as yet been re-instated. General practitioners are,

however, encouraged to intimate cases to the department. In 1954, 72 cases were voluntarily intimated, and there were no deaths. The corresponding intimations for 1953 were 247 cases with no deaths, while, in 1952, there were 801 intimated cases and no deaths, and in 1951, 824 cases and one death.

Ophthalmia Neonatorum.

No case was notified in 1954. There was a case in 1953 and this was the only one during the last five years. The virtual eradication of this formerly serious cause of blindness constitutes one of the major triumphs of preventive medicine.

Pneumonia, Acute Influenzal.

Twenty-three cases were notified in 1954. Eighteen occurred during the months of November and December. Two deaths occurred, one in a male aged 87 years and the other a female aged 52 years. In the preceding year five cases were notified with one death.

Pneumonia, Acute Primary.

During 1954, 294 cases were notified, with 19 deaths, as compared with 263 cases and 9 deaths in 1953. During the ten years, 1944-1953, the annual average number of cases was 367, and the annual average number of deaths was 37. Of the 294 cases in 1954, 222 or 76 per cent. received institutional treatment.

Poliomyelitis (Infantile Paralysis).

Thirty-four cases of this disease were notified in 1954, as compared with 12 in 1953 and 18 in 1952.

In 1954, there was one death from the disease, a boy of 16. It may be worth while to mention that, in the 68 cases occurring in the years 1951-1954, there have been only three deaths.

Of the 34 cases notified in 1954, 9 were non-paralytic, while the others had temporary or permanent paralysis of varying degree. Two patients, including the one who died, suffered from paralysis of the respiratory system.

Puerperal Fever and Puerperal Pyrexia.

Twelve cases of puerperal fever and puerperal pyrexia were notified. Two cases were confirmed as suffering from puerperal fever. No deaths were registered from this cause. The annual average number of cases and deaths in the preceding ten years was 31 and 1 respectively.

Ten cases were classified as cases of puerperal pyrexia. In the preceding decennium, the annual average number of these cases was 17.

The 2 cases of puerperal fever and 8 of the 10 cases of puerperal pyrexia received institutional treatment in the City Hospital.

Scarlet Fever.

In 1954, 178 cases of scarlet fever were notified, as compared with an annual average of 308 in the decennium 1944-1953. There were no deaths for the sixth consecutive year. In recent years this disease has assumed a very mild character,

Smallpox.

Aberdeen has remained free from smallpox since 1930.

Analysis of the vaccinations carried out in 1954 by general practitioners and at child welfare clinics is given in an earlier section of this Report.

Typhoid and Paratyphoid Fevers.

There were no cases of typhoid fever but sixteen cases of paratyphoid Fever B were notified in 1954. None of the cases proved fatal.

Whooping Cough.

On 1st January, 1950, this disease became compulsorily notifiable. The number of cases notified during 1954 was 284, as compared with 175 in the preceding year. During 1952, 1953, and 1954, no deaths occurred.

As indicated elsewhere in this Report, whooping cough immunisation among infants and pre-school children is carried out at the various Child Welfare Centres and at home by general practitioners. During 1954, the number of children so immunised was 2,483 as compared with 2,475 in the previous year.

Infections generally.

The following tables deal with the various infectious diseases. Table I shows the seasonal variations in the prevalence of each infectious disease, whether compulsorily notifiable or not. In Table II are given the morbidity and mortality from infectious diseases, classified according to age and to the allocation of patients to institutions for purposes of treatment. In Table III, the cases and deaths are detailed for each of the years from 1944 to 1954.

Arrangements for Laboratory Services.

Until 1948 the Corporation provided an up-to-date laboratory at the City Hospital, and, by arrangement with the Regional Hospital Board, the laboratory is still available to the authority. The Public Analyst, who is an employee of the Corporation, works in the laboratory at the City Hospital and undertakes some biochemical work for the Hospital Board. The arrangement works satisfactorily.

TABLE I.—PROGRESS OF INFECTIOUS DISEASES (EXCLUDING TUBERCULOSIS)
DURING TWELVE MONTHS—YEAR, 1954.

Disease.		1954.												Whole Year.
		Jan.	Feb.	Mar.	Apr.	May.	June.	July.	Aug.	Sept.	Oct.	Nov.	Dec.	
Cerebro-spinal	{ Cases	1	1	—	—	1	1	—	—	—	—	—	4	8
Fever.	{ Deaths	—	—	—	—	—	1	—	—	—	—	—	—	1
*Chickenpox	{ Cases	—	—	1	3	3	2	—	1	—	—	—	1	11
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Continued Fever	{ Cases	2	—	—	—	—	—	—	—	—	—	—	—	2
(Undulant)	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Diphtheria	{ Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Dysentery	{ Cases	19	15	17	13	8	6	1	6	10	25	5	4	129
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Encephalitis	{ Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Lethargica	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Erysipelas	{ Cases	4	3	3	2	3	2	2	1	1	4	7	1	33
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Jaundice, Acute	{ Cases	—	—	—	—	—	—	—	1	—	1	—	—	2
Infective	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Leprosy	{ Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Malaria	{ Cases	—	—	—	—	—	—	—	1	—	—	—	—	1
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
*Measles	{ Cases	—	—	—	—	1	4	1	2	13	22	15	14	72
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Ophthalmia	{ Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Neonatorum	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Plague	{ Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Pneumonia	{ Cases	—	1	—	—	3	1	—	—	—	—	12	6	23
Acute	{ Deaths	—	—	—	—	—	—	—	—	—	—	2	—	2
Influenzal	{ Cases	38	53	31	18	25	21	15	9	9	16	33	26	294
Pneumonia,	{ Deaths	1	—	—	3	2	2	1	—	3	—	4	3	19
Acute Primary	{ Cases	1	—	—	—	2	4	3	5	6	5	8	—	34
Poliomyelitis,	{ Deaths	—	—	—	—	—	—	—	—	—	—	1	—	1
Acute	{ Cases	—	—	—	—	1	1	—	—	—	—	—	—	2
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Fever	{ Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	{ Cases	1	—	2	3	—	2	—	—	—	1	—	1	10
	{ Deaths	17	21	18	19	18	9	6	6	7	18	25	14	178
Scarlet Fever	{ Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Smallpox	{ Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	{ Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid	{ Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
A.	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid	{ Cases	—	—	—	—	—	—	—	—	—	3	13	—	16
B.	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	{ Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Whooping	{ Cases	2	4	7	2	3	11	—	7	15	49	88	96	284
Cough	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	{ Cases	85	98	79	60	68	64	28	39	61	144	206	167	1,099
	{ Deaths	1	—	—	3	2	3	1	—	3	—	7	3	23
Influenza, excl.	{ Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Pneumonia	{ Deaths	—	—	—	—	—	—	—	—	—	—	—	1	1

*Not compulsorily notifiable.

TABLE II.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES
(EXCLUDING TUBERCULOSIS) DURING 1954.

DISEASE	NO. OF CASES AND DEATHS AT VARIOUS AGE-PERIODS										Cases receiving Institutional Treatment	Cases not receiving Institutional Treatment
	At all Ages	YEARS										
		Under 1	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 65	65 and upwards			
Cerebro-spinal Fever	Cases	8	2	4	2	—	—	—	—	—	8	—
	Deaths	1	—	1	—	—	—	—	—	—	1	—
*Chicken Pox ...	Cases	11	1	6	3	1	—	—	—	—	10	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Cholera	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Continued Fever (undulant)	Cases	2	—	—	—	—	—	—	1	1	1	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Diphtheria	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Dysentery	Cases	129	8	66	24	9	5	3	13	1	60	69
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Encephalitis Lethargica...	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Erysipelas	Cases	33	—	—	—	2	6	18	7	—	11	22
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Infective Jaundice ...	Cases	2	—	—	1	—	1	—	—	—	1	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Malaria	Cases	1	—	—	—	1	—	—	—	—	1	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
*Measles	Cases	72	—	12	58	1	1	—	—	—	16	56
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Plague	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Pneumonia, Acute Influenzal	Cases	23	—	1	6	1	3	—	5	7	5	18
	Deaths	2	—	—	—	—	—	—	1	1	1	1
Pneumonia, Acute Primary	Cases	294	26	34	54	15	15	20	57	73	222	72
	Deaths	19	1	—	3	—	—	1	3	11	15	4
Poliomyelitis, Acute	Cases	34	4	13	7	4	2	2	2	—	34	—
	Deaths	1	—	—	—	1	—	—	—	—	1	—
Puerperal Fever	Cases	2	—	—	—	—	1	1	—	—	2	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	10	—	—	6	4	—	—	—	—	8	2
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Scarlet Fever...	Cases	178	1	65	107	1	1	2	1	—	35	143
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Small-pox	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Paratyphoid A	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Paratyphoid B	Cases	16	1	2	4	1	1	2	3	2	16	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough	Cases	284	41	105	135	1	—	1	—	1	18	266
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Total ...	Cases	1099	84	308	400	41	36	38	100	92	448	651
	Deaths	23	1	1	3	1	—	1	4	12	18	5

* Not compulsorily notifiable.

TABLE III.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES, INCLUDING TUBERCULOSIS, DURING EACH YEAR FROM 1944 TO 1954.

Disease.		1954	1953	1952	1951	1950	1949	1948	1947	1946	1945	1944	ANNUAL AVERAGE 1944 to 1953.
Cerebro-Spinal Fever . . .	Cases	8	10	7	24	14	9	5	12	28	25	8	14.2
	Deaths	1	0	0	0	0	1	2	2	0	3	0	0.8
*Chickenpox . . .	Cases	11	12	48	16	26	23	62	23	60	14	36	32.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Continued Fever (Undulant) . . .	Cases	2	0	1	0	9	4	1	3	4	1	1	2.4
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Diphtheria . . .	Cases	0	0	3	0	2	3	4	9	68	136	153	37.8
	Deaths	0	0	0	0	1	0	0	0	0	9	5	1.5
Dysentery . . .	Cases	129	110	14	225	67	34	137	13	100	331	83	111.4
	Deaths	0	0	0	1	0	0	1	0	0	3	5	1.0
Encephalitis Lethargica . . .	Cases	0	0	0	0	1	0	0	0	0	0	0	0.1
	Deaths	0	0	0	0	1	0	0	0	0	0	0	0.1
Erysipelas . . .	Cases	33	27	32	23	37	48	64	65	104	79	54	53.3
	Deaths	0	1	0	1	0	0	0	0	2	2	0	0.6
Infective Jaundice . . .	Cases	2	13	10	4	10	11	10	6	6	4	4	7.8
	Deaths	0	0	1	2	0	1	3	0	2	0	0	0.9
Leprosy . . .	Cases	0	0	0	0	0	9	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Malaria . . .	Cases	1	6	2	1	8	9	4	9	23	0	0	6.2
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
*Measles . . .	Cases	72	247	801	824	26	402	199	527	500	887	245	465.8
	Deaths	0	0	0	1	1	1	1	3	0	3	0	1.0
Ophth. Neonatorum . . .	Cases	0	1	0	0	0	1	3	7	6	3	6	2.7
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Plague . . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Pneumonia, Acute Influenzal . . .	Cases	23	5	18	10	32	19	7	4	13	3	12	11.4
	Deaths	2	1	5	2	7	4	3	2	7	0	2	3.3
Pneumonia, Acute Primary . . .	Cases	294	263	301	242	422	443	444	404	379	347	424	366.9
	Deaths	19	9	13	43	58	41	42	53	38	34	40	37.1
Poliomyelitis, Acute . . .	Cases	34	12	18	4	36	3	5	48	1	0	20	14.7
	Deaths	1	1	1	0	2	0	0	6	0	0	2	1.2
Puerperal Fever . . .	Cases	2	26	17	13	35	46	25	42	52	37	24	31.7
	Deaths	0	1	0	1	0	1	0	1	1	2	1	0.8
Puerperal Pyrexia . . .	Cases	10	13	13	10	11	13	34	33	26	4	13	17.0
	Deaths	178	239	314	299	513	275	252	205	465	316	202	308.0
Scarlet Fever . . .	Cases	0	0	0	0	0	0	1	0	0	0	0	0.1
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Smallpox . . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Tuberculosis, Respiratory . . .	Cases	228	243	230	226	270	222	279	172	190	207	171	221.0
	Deaths	19	26	36	36	38	60	62	65	71	70	77	54.1
Tuberculosis, Non- Respiratory . . .	Cases	26	31	30	31	31	28	37	53	50	48	63	40.2
	Deaths	4	4	4	5	5	6	8	12	12	15	33	10.4
Typhoid and Para- typhoid Fevers . . .	Cases	16	3	10	4	2	4	30	6	2	7	3	7.1
	Deaths	0	0	0	0	0	0	0	1	0	0	0	0.1
Typhus Fever . . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Whooping Cough . . .	Cases	284	175	549	551	449	58	194	176	151	195	346	284.4
	Deaths	0	0	0	3	0	0	2	5	3	4	2	1.9
Influenza, excl. Influenzal Pneumonia . . .	Deaths	1	2	0	7	6	6	1	0	2	7	5	3.6

*Not compulsorily notifiable.

13.—MENTAL HEALTH.

The main developments in mental health work in the recent past were— (1) the appointment (just before the end of 1953) of a Senior Assistant Medical Officer with duties primarily in the mental field, and (2) the provision, in 1954, of a post-qualification course in mental health to equip health visitors more fully for their work in mental health education. The course is discussed in the section of the report dealing with training of health visitors.

I. ADMINISTRATION.

(1) Duties.

Although the Corporation have no responsibility for the institutional care of the mentally sick, they are responsible for each of the following aspects:—Prevention of mental disease; ascertainment, care and after-care of mental defectives and mentally ill persons in their own homes; and provision of suitable training and occupation for mental defectives over the age of 16 years and for ineducable defectives under that age.

(2) Committee Responsible.

The responsible Committee is the Health and Welfare Committee, except in the case of educable defectives under guardianship and aged 5 to 16 years. The latter are the responsibility of the Education Committee.

(3) Number and Qualifications of Staff Employed.

(a) *Medical Officers*.—The certification of insane persons requires two certificates. In general, the first of these certificates is given by the Medical Officer for Mental Health of the North-Eastern Regional Hospital Board, or, in his absence, by one of two other specialists in mental disease whose services have been made available to general practitioners by arrangements with the Executive Council. The second certificate is usually completed by the general practitioner normally attending the patient.

As indicated above, duties in regard to prevention, ascertainment, supervision, and after-care devolve on the medical officers of the Health and Welfare Department. The Medical Officer of Health and several of the Departmental Medical Officers possess the post-graduate certificate in mental assessment.

In the report for 1952 it was stated that the post of Assistant Medical Officer of Health whose duties were primarily in the field of mental health could not be filled because of lack of suitable candidates, and the Corporation agreed in 1953 that this post be up-graded to that of Senior Assistant Medical Officer, with a consequent increase of salary. After advertisement, the post was filled by the appointment of Dr. Dorothy Younie, who took up duty in September, 1953.

(b) *Psychiatric Social Worker*.—The Corporation have not appointed any psychiatric social worker. Until the middle of 1952, an arrangement operated whereby a psychiatric social worker employed by the University Department of Mental Health was available for a limited amount of time. When the last holder of that post left, the University decided for the present not to replace her. On occasions, a psychiatric

social worker from the Regional Hospital Board visits local authority cases by special request.

(c) *Health Visitors*.—The establishment has been raised to 85 and at the end of the year 61 were employed. As mentioned in the section of the report dealing with training of health visitors, during the year, 20 health visitors attended a post-qualification course on mental health.

(d) *Other Mental Health Workers*.—As yet, none is employed.

(e) *Duly Authorised Officers*.—The Senior Assistant Welfare Officer has been designated authorised officer. His duties as authorised officer are (1) to make arrangements for the detention of persons apparently of unsound mind who have no relatives or friends willing or able to take such action; (2) to ensure that adequate domestic arrangements have been made when it is proposed to discharge insane persons from mental hospitals; (3) on the instructions of the Medical Officer of Health, to take steps to remove, pending the presentation of a petition, a supposed defective who is neglected, cruelly treated, or without visible means of support, to a place of safety; and (4) to deal with certain types of mentally handicapped children. The Senior Assistant Welfare Officer is assisted by three Assistant Welfare Officers, who are fully trained and versed in mental health certification procedure, &c.

(f) *Occupation Centre Supervisors, &c.*—As yet, none is employed. (The Corporation has approved of the provision of an occupation centre, but suitable premises have not yet been secured).

(4) Co-ordination.

Close liaison is maintained with the North-Eastern Regional Hospital Board and with the Board of Management for the Mental Hospitals.

On the one hand, where a certified defective is placed under guardianship or is boarded out or liberated on licence from a mental hospital, supervision, although legally a matter for the hospital authorities, is undertaken by members of the Corporation staff. On the other hand, in carrying out duties relating to mental illness and mental deficiency, the medical officers of the Corporation have the valuable co-operation and help of the Regional Hospital Board Medical Officer for Mental Health, of the Professor of Mental Health, and of the Physician Superintendents of Kingseat Mental Hospital and the Aberdeen Royal Mental Hospital. The co-operation is good and is much appreciated on both sides.

(5) Duties delegated to Voluntary Associations.

No duties in relation to mental cases have been delegated to any voluntary associations, all duties being carried out by members of the Health and Welfare Department, with the exception of such duties as are, by mutual agreement, carried out by officers of the Regional Hospital Board (as mentioned above).

(6) Training of Staff.

No particular arrangements have been made, apart from (a) the provision of the post-qualification course for mental health for health visitors, mentioned above, and (b) the sending of an occasional medical officer to mental deficiency courses.

II. AMOUNT OF WORK UNDERTAKEN.

1. Under Section 27 of the National Health Service (Scotland) Act.

(a) *Measures for prevention of Mental Illness.*

(i) *Health Education by Health Visitors and by Departmental Medical Officers.*

This constitutes an important part of the normal health education work undertaken by the department. As more and more of the physical diseases are conquered, the amount of attention focussed on mental health is being proportionately increased.

The role of the family health visitor—an expert in normality, skilled in the art of persuading, and recognised by the family as a health counsellor—is of particular importance.

(ii) *Attempts to assist families placed in situations of abnormal physical or mental or financial strain.*

For households under physical strain, home helps are available, as indicated elsewhere in this report. Again, physical strain on parents is frequently relieved by admission of young children to day or less frequently to residential nurseries. Financial strain is again often relieved by the same means, the mother being, for a time, enabled to undertake whole-time or part-time work with a view to obtaining sufficient money to permit of the paying off of debts, &c.

The health visitors give a vast amount of useful advice and guidance on family budgeting and on general domestic problems, and there is, in addition, a fairly good liaison with the National Assistance Board and with the various voluntary societies.

Not the least important factor in assistance of families in situations of abnormal physical, mental, or financial strain is the existence of a Joint Committee (already mentioned in this report) to deal with measures for the assistance of children who are neglected in their own homes. This Committee, by co-ordinating the efforts of health visitors and school nurses, school welfare officers, the National Society for the Prevention of Cruelty to Children, the National Assistance Board, and so on, as well as of bodies like the Council of Social Service, can very often find a practical means of relieving an intolerable strain on households. In addition, this co-ordinating mechanism makes for economy in that the number of persons concerned with each of these difficult families is kept down to a minimum.

(b) *Care and After-care of the Mentally Ill and Mental Defective.*

All patients released on probation from mental institutions and residing within the City or boarded out within the City are visited regularly by the authorised officer or one of the assistant welfare officers and are also medically supervised by a medical officer versed in mental health.

There is still a grave lack of institutional accommodation for mentally defective persons who are in need of institutional care and supervision, and there is also a grave need for an occupation centre for defectives living at home.

2. Under Lunacy Act by Duly Authorised Officer and by Medical Staff.

The work undertaken under the Lunacy Act includes advice and guidance on budgeting and general domestic problems, reference to psychiatric clinic so as to

secure early preventive treatment, where necessary; close liaison between general medical practitioners and psychiatric specialists and Welfare Department so as to ensure help of any nature required for mentally sick person; completing and negotiating claims of all types of statutory benefits under the welfare, insurance, and sundry pensions Acts; ensuring adequate protection for property prior to admission to hospital and throughout any period of hospitalisation so as to allay any anxiety over such personal responsibilities which might otherwise retard the desired early improvement and recovery of patients; ensuring the proper care and supervision of all patients boarded out under guardianship and on probation or licence from mental institutions; and securing the certification of patients in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947, and the various Lunacy Acts.

The following is a short statement of the cases dealt with by the department during the year:—

Number of mental cases dealt with in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947, and Lunacy Acts.

	Males.	Females.	Total.
Cases fully certified under the Lunacy Acts, following medical examination	58	79	137
Cases admitted as voluntary boarders, following medical examination	57	86	143
Cases where no action was recommended following medical examination	12	9	21
	<hr/> 127	<hr/> 174	<hr/> 301

Number of patients on probation from mental hospitals who are under supervision.

Males.	Females.	Total.
7	5	12

Number of mental patients boarded-out from mental hospitals under private guardianship who are under care and supervision.

Males.	Females.	Total.
7	2	9

Number of patients on licence from certified institutions who are under care and supervision.

Males.	Females.	Total.
1	—	1

Number of reports to physician superintendents on home conditions prior to release of patients on probation, in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947.

Males.	Females.	Total.
10	4	14

Mental Deficiency and Lunacy (Scotland) Acts, 1913-1940.

	Males.	Females.	Total.
Number of cases reported by the Education Department	14	7	21
Number of cases committed to certified institutions by the department	8	5	13

Number of cases under guardianship as at 31.12.1954.

	Males.	Females.	Total.
In the City	11	7	18
Outwith the City	13	6	19

(There were, at the end of 1954, 39 mentally-handicapped children in the City awaiting admission to certified institutions.)

14.—WORK UNDER NURSERIES AND CHILD-MINDERS' REGULATION ACT.

The Nurseries and Child-Minders' Regulation Act, 1948, which came into operation on 30th July, 1948, empowers local authorities to supervise (i) nurseries where children up to school age are looked after for a day, or for longer periods not exceeding six days, and (ii) persons who, for reward, undertake the care of children under the age of five years for similar periods.

There were no applications for registration during the year.

15.—SCHOOL HEALTH SERVICE.

Some of the main features of the year are outlined below:—

- (1) Until 1953 the child guidance clinic was handicapped by the fact that no medical officer was available for the physical assessment of children referred there; from October, 1953, a medical officer has devoted one session each week to examinations at the clinic.
- (2) Although the list of children waiting for mental testing was cleared by intensive work during 1952-53, until the year under review little work was undertaken in respect of mentally handicapped children other than initial assessment; in 1953-54 several developments took place—*e.g.*, 39 children previously admitted to the Special School were re-tested, 10 children admitted to Polmuir Road School for the Deaf had their intelligence tested by special methods, and 31 children previously reported as ineducable and still remaining at home were visited with a view to occupational centre training.
- (3) An attempt was begun to investigate all school children absent from school for a period of longer than three months; liaison with hospital staffs and general practitioners is being developed regarding the schooling of invalid children.
- (4) A survey was begun of children in residential schools.
- (5) During the first full year's work of the audiometrician, the hearing of 7,969 pupils was tested audiometrically.
- (6) The Corporation decided to employ an orthoptist for the more adequate treatment of children with squints.
- (7) After the general survey of the hygienic conditions of schools made in 1953 (and outlined in the Report for 1952-53), many of the defects found were remedied; and in 1953-54 a more detailed survey was made of lavatory and washing facilities.
- (8) As might have been forecast from the association found last year between squint and overcrowding, and from the progress of housing in the City, the incidence of squint in school entrants showed an appreciable decline.
- (9) The number of children re-inspected by medical officers, though still a little inadequate, was more than twice as large as the number in the previous year.

- (10) The number of inspections by health visitors was greater than in any former year, and the number of follow-up inspections by health visitors was more than twice as large as the number in the previous year.
- (11) The number of home visits paid by health visitors, though still inadequate, was greater than in previous years.
- (12) The number of dental inspections, although still very inadequate, was greater than in previous years.
- (13) The proportion of children with parents present at medical inspections—83·1 per cent.—was the highest yet recorded in Aberdeen.
- (14) During visits to the schools the health visitors, while not neglecting "cleanliness," paid increased attention to nutritional conditions, fatigue, nervousness, debility, postural defects, &c.; and they endeavoured to put the emphasis on the promotion and maintenance of physical and mental health and on the prevention of disease, rather than on detection of defects.
- (15) Satisfactory features of the findings of school medical inspection included a sharp decline in the number of children with dirty heads, a reduction in the already small number with defective clothing and footgear, the virtual disappearance of ringworm, and decreases in the prevalence of diseases of the heart and the lungs.
- (16) An unsatisfactory feature of the year was an increase in the number of school entrants judged to be of defective nutrition.

Points to which attention might profitably be devoted in the future include—

- (a) Better integration of the Child Welfare and School Health Services.
In particular it seems anomalous that, although the health visitors have for some years successfully combined the duties of health visitor and school nurse, the medical officers are still segregated in sectionalised work. It is hoped that, after the appointment (sanctioned in 1954) of an additional medical officer, it will be possible gradually to transform child welfare medical officers and school medical officers into all-purpose departmental medical officers.
- (b) More emphasis on health education. The improvement of the health of the community depends largely on health education. While some instruction on health is already being given in schools, and while some medical officers and health visitors are already availing themselves of opportunities to address parent-teacher associations and similar bodies, a great deal remains to be done. An increase in the number of health visitors (under consideration at the end of the year and subsequently sanctioned by the Health and Welfare Committee) should help considerably, but, in addition, it will probably be necessary to set up a Health Education Section of the Health and Welfare Department, as has already been done in some cities and counties.

- (c) Information to teachers about the role of the health visitor. Because in the early days school nurses found it necessary to concentrate on "cleanliness" and on the detection of the more obvious physical defects, a substantial minority of teachers have not yet realised that the health visitor is a highly trained professional officer whose expert advice can do much to promote the mental and physical well-being of children; and some teachers do not fully appreciate that the health visitor—by reason of her knowledge both of home and of school and by reason of the authority deriving from her triple training as State registered nurse, midwife, and health visitor—is in an ideal position to form a link between home and school and to ensure that the influences of parents and teachers do not operate in contrary directions.
- (d) Re-organisation and development of the dental section. Nobody can remain content with a service under which only one sixth of the children are dentally examined in a year.
- (e) Allocation of a medical officer for administration of anæsthetics at the central dental clinic. (This was under consideration at the end of the year, and a medical officer was allocated for one weekly session shortly after the close of the school year).
- (f) Further investigation of the educational requirements of deaf children and advice to mothers of young deaf children.
- (g) The provision of physiotherapy for certain physically handicapped children.
- (h) Better liaison with Youth Employment Officers regarding school leavers.

STAFFING.

Medical.—With the appointment of a senior assistant medical officer just after the beginning of the school year, the number of doctors available for the health supervision of 29,976 school children rose to four, or a ratio of one medical officer for every 7,495 children. As was pointed out in the Report for 1952-53, however, the optimum ratio is about one medical officer for every 5,000-6,000 children. Hence, medical understaffing persisted throughout the year, although to a smaller degree than in the past.

The decision (taken during the year but not effective until 1954-55) to appoint to the staff of the Health and Welfare Department another full-time doctor and to make available to the School Health Service half the time of that doctor (or an equivalent number of sessions by other doctors) should bring the medical staffing to a reasonably adequate level.

To lessen strain, an additional doctor was employed for three months in connection with diphtheria immunisation work.

Dental.—At the beginning of the school year, four dental officers (as compared with an authorised establishment of seven) were available for all dental work. The

situation was eased slightly by the appointment of a fifth dental officer on a part-time basis, but about the same time the health of Miss J. L. Rea, L.D.S., again broke down. After a prolonged illness, Miss Rea died in June, 1954.

At the end of the year Mr. E. G. H. Lightfoot, L.D.S., resigned his appointment of Chief Dental Officer to take up a similar appointment in England.

The extreme shortage of dental staff accounts for the fact that less than one sixth of all children were dentally inspected during the year. Nevertheless, it is pleasant to record a considerable increase in the number of such inspections; from 3,547 in 1952-53 to 4,853 in 1953-54.

Nursing.—To prevent needless breaks in the health supervision of children at the age of five years, the work of school nurses is carried out by the Corporation's health visitors. The numbers employed during 1953-54 may be reckoned as equivalent to about nine full-time school nurses.

A more adequate number will, of course, be employed when it becomes possible to fill existing vacancies. Even the slight staffing increase in 1953-54 enabled the number of nurses' inspections to rise to 55,241 (as compared with 54,168 in the previous year) and the number of home visits to rise to 2,264 (as compared with 1,753 in 1952-53).

Ancillary Staff.—A full-time audiometrician was employed throughout the year. The appointment of an orthoptist was sanctioned by the Corporation, but advertisements failed to attract candidates.

GENERAL STATISTICS.

The increase in the school population continues, the numbers on the registers being approximately 650 more than in the previous session, and about 1,300 more than in 1951-52. The rise is in the main a result of the high birth rates of the years 1946-48. Details of schools and scholars are given below.

Number of schools—

(a) Primary—Under Education Authority	41
(b) Junior Secondary do. do.	10
(c) Secondary do. do.	3
(d) Nursery do. do.	4
(e) (i) Special Schools	2
(ii) Special Classes in ordinary schools	—
(iii) Nursery Classes	7
(f) In receipt of grant from Education Committee and under Medical Inspection	2
Number of children on the registers	29,978
Number of children in average attendance	28,145

SANITARY CONDITION OF SCHOOLS.

In general, the physical and sanitary conditions of the schools are satisfactory. In the last few years a considerable amount of building of new schools and

reconstruction of older schools has been undertaken, and during the school year under review the following work has been in progress:—

Position at end of school year.

(a) *New Schools—*

Cairnery	Under construction.
Kingswood	Do.
Quarryhill	Do.
Burnside (temporary)	Work completed.
Westerton	Still under construction.
Inchgarth	Work completed.
Beechwood Special	Almost completed.

(b) *Reconstructions, &c.—*

Middle Junior Secondary	Almost completed.
Rosemount Junior Secondary	Work in progress.
Central Secondary	Almost completed.

Schools repainted during the year included Frederick Street Junior Secondary, Torry Junior Secondary (part), Stockethill Infant, Tillydrone Infant, Torry and Hilton Nursery Schools.

During their routine visits, the school doctors and nurses continued to pay attention to the ventilation, heating, cleanliness, and hygienic conditions generally of classrooms, cloakrooms, and lavatories; and in addition inspectors from the Sanitary Section of the Health and Welfare Department visited the schools periodically. During the year 24 defects in 15 schools were notified to the Architect's Department. These points—usually minor defects in sanitary conveniences, drinking fountains, washing facilities, &c.—were duly rectified.

The sanitary conveniences in general continue to be kept in a satisfactory condition and the regulations for disinfection and cleansing of the schools are adequately implemented. The provision of fluorescent lighting in the new and re-constructed schools is an improvement on the older forms of artificial lighting, and there is no evidence that this form of artificial lighting is detrimental to the eyesight of children or teaching staff.

During the year (following the special hygiene survey undertaken in the previous year) a detailed study was made of washing and lavatory facilities in the sixty schools in the City. The findings may be summarised thus—

(1) Wash-basins—		Number of Schools.
Clean		46
Mostly clean		13
Mostly dirty		1
(2) Soap—		
Available and sufficient		53
Insufficient		6
None		1

(3) Cold water—	Number of Schools.
Plentiful	60
(4) Hot water—	
Plentiful	52
Insufficient	2
None	6
(5) Drying facilities—	
Air driers or towels satisfactory	54
Towels dirty or insufficient	6
(6) Toilets—	
Clean	45
Mostly clean	11
Mostly dirty	4
(7) Flushes of toilets—	
Working	56
One not working	3
Two not working	1
(8) Toilet paper—	
Available	42
Available on request to teacher	8
Insufficient	6
None	4
(9) Facilities for disposal of sanitary towels (in 16 schools with senior girls)—	
Available	11
None	5
(10) Facilities for procuring sanitary towels (in 16 schools with senior girls)—	
Available	15
None	1

ORGANISATION AND ADMINISTRATION.

A. SYSTEM AND EXTENT OF MEDICAL INSPECTION AND TREATMENT.

During the school year 1953-54 routine medical inspection was undertaken in respect of children in certain age-groups stipulated by D.H.S. Circular 55/1953, namely, entrants (approximately 5 years of age), pupils born in 1944 (approximately 9 years of age), those born in 1940 (approximately 13), and those born in 1937 (approximately 16). In addition, a quick and less comprehensive survey was made of school entrants as soon as practicable after their initial entry.

In general, medical inspection was conducted as in previous years; and, in the first full year's work of the audiometrician, the hearing of 7,969 pupils was tested by the pure tone audiometer.

The purpose of routine medical overhauls is twofold. In the first place, they permit of the detection of early defects, which in many cases have hitherto been unsuspected by the parents, as well as the identification of more obvious diseased conditions; and advice is given about the most suitable measures by which the defects can be remedied. Secondly, and probably of even greater importance, advantage is taken of the presence of the parent to inculcate ideas of health maintenance. Indeed, this is a valuable facet of the campaign of health education in the schools.

In practically all cases of disease or defects requiring medical treatment, the parents are strongly advised to consult their general practitioners. The provision of the National Health Service Act for "free" treatment has made a considerable difference to the readiness of parents to take their children to the family doctor. Nevertheless, there is still ample need for the school clinics (*e.g.*, Minor Ailments Clinics, Skin Diseases Clinic, Eye Clinic, Ear, Nose, and Throat Clinic, Orthopædic Clinic, and Dental Clinics).

It is interesting to note that the numbers of children attending the Minor Ailments Clinics and the Skin Diseases Clinic continue to increase. The various clinics are mentioned in more detail later in this report.

B. SYSTEM AND EXTENT OF DENTAL INSPECTION AND TREATMENT.

There has been no material change in the scheme of dental inspection and treatment. The schools are visited in rotation by the dental officers, first priority being accorded to children aged 6-7 years. Children suffering from defects are noted at these dental inspections in schools, and cards are sent to parents advising them to accept treatment at the school dental clinics or to have the children treated privately. From the acceptances received, appointments are made through the schools for treatment at either the main or the branch clinics.

Unfortunately, owing to the grave shortage of dental officers, only a fraction of the children can as yet be examined, and emergency cases (usually toothache) cannot always be undertaken. The treatment carried out is as far as possible on conservative lines, and teeth are extracted only if they are beyond saving. Treatment under general anaesthesia occupies part of the forenoons of two of the dental officers.

In addition to school children, the dental officers deal with cases referred from the Maternity and Child Welfare Clinics.

C. SCHOOL NURSING AND ARRANGEMENTS FOR FOLLOWING-UP.

The School Nursing Service is provided by health visitors who, as far as practicable, are allocated schools serving their particular districts.

Medical Inspection.—According to what is still the standard practice in most areas, the health visitor of the district accompanies the medical officer in school during a medical inspection—the weighing, measuring, and vision-testing of the

children having taken place a few days previously. The health visitor can usually give valuable information to the medical officer about the child's progress, background, and home conditions, and the contact with the mother at the time of medical inspection is helpful to the health visitor in her future work with the child and the family.

Follow-up and Home Visiting.—Work of very high value is done by the health visitors in the follow-up of children found at routine medical inspection to be in need of observation or treatment. This work entails numerous visits to schools and quite a lot of clerical work by the nurses to maintain adequate records. Home visits are paid in many cases as an essential part of follow-up, to ascertain whether treatment recommended for the child is being carried out, or to explain and interpret to parents the need for further examination or treatment. Such visits are also made to obtain any necessary information about the child's home background.

If the school health visitor is to fulfil her important duty of acting as a link between home and school, an adequate number of home visits is essential, but the frequency of visits is, of course, governed by the adequacy or otherwise of the available staff.

Hygiene Inspections by the Health Visitors in Schools.—These inspections are perhaps the most important part of the whole school health service. They have been carried out in all Primary, Junior Secondary, and Special Schools at least once every three months during the school session. Many children who are not making reasonable educational or physical progress, who show signs of early disease, or who present deviations from normal growth, development, or behaviour are picked out in this way, given any necessary advice, and—where needful—referred to the school medical officers or to general practitioners. At these hygiene inspections by the nursing staff, children found to be malnourished, showing signs of excessive fatigue, nervous, dirty, inadequately clad, malodorous, or suffering from pediculosis are particularly noted and the homes visited where the health visitor deems this course desirable. During these hygienic inspections a great deal of informal instruction on health and personal hygiene is given to individual children and to small groups as the need and the opportunity arises. Although much of the home visiting done by the health visitors has in the past been for cases of neglect and dirty conditions, increasing attention is now being devoted to physical defects and behaviour problems. At the end of the school year the health-visiting staff consisted of 59 nurses, most of whom devoted approximately twenty per cent. of their time to school health work.

Home visitation is also undertaken by the male inspector attached to the school health service when it is required in connection with arrangements for treatment of scabies and verminous cases, failure to provide spectacles or other treatment prescribed, and investigation of family circumstances for various reasons.

D. CO-ORDINATION WITH THE PUBLIC HEALTH SERVICE AND WITH OTHER DEPARTMENTS OF THE AUTHORITY WHICH RENDER SERVICES TO CHILDREN.

Co-operation with the other departments of the public health service in Aberdeen is ensured by the fact that the School Health Department is part of the Health

and Welfare Department. As already mentioned, health visitors act as school nurses, and, although the medical officers are still attached to a single section (*e.g.*, working full-time on school health work), there is a very close liaison. For instance, appropriate cases are referred to the school eye and dental clinics by the Maternity and Child Welfare Section, and the entire resources of the Health and Welfare Department are available at need. Cases of suspicious chest conditions are referred for investigation to the Chest Clinic under the Regional Hospital Board. With regard to the control of infectious diseases, information about the incidence of the non-notifiable infectious diseases (such as measles, rubella, and chickenpox) often comes to the Health and Welfare Department through the School Welfare (formerly Attendance) Department, and the statutory certificates of exclusion from school on account of infectious diseases are transmitted to the head teachers through that department.

Visits are paid to the Remand Home (which is under the control of the Children's Department) for the purpose of examining children (usually delinquents) on entry to the Home and also for the statutory examination, both physical and mental, of children about to be admitted to approved schools. Children admitted to the Reception Centre under the Children's Department are also medically examined.

E. CO-OPERATION WITH VOLUNTARY BODIES AND OTHER OUTSIDE AGENCIES.

Full co-operation exists between the department and certain voluntary agencies which render services to children. Although, as noted before, children in need of medical and surgical treatment are in the first place generally referred to the family doctor, certain types of cases are referred directly to Aberdeen Royal Infirmary or the Royal Aberdeen Hospital for Sick Children, according to circumstances. There is, for example, a long-standing arrangement with the Skin Out-Patient Departments of these institutions to treat children suffering from ringworm (particularly those who are likely to require x-ray treatment), verrucosis, &c. Similarly, the Eye Institution deals with cases of epidemic conjunctivitis occurring in school children. The Cleansing Station at the City Hospital, under the management of the Special Hospitals Management Committee, continues to deal with cases of scabies and dirty and verminous conditions occurring in school children and their families, the family being treated as a unit wherever possible. Again, there is a long-standing arrangement with the Committee of Linn Moor Convalescent Home, Culter, by which school children suffering from pre-tuberculous conditions, debilitated, malnourished, or convalescent from illness are given a period in the Home, the duration varying according to the circumstances of the case.

Any children who (*e.g.*, by reason of the mother's removal to hospital) are to be temporarily cared for in the Children's Shelter, managed by the Aberdeen Association of Social Service, are examined by the school medical officers before admission in order to exclude the possibilities of infectious or contagious diseases.

Where appropriate, the school health service also co-operates with the Society for the Prevention of Cruelty to Children.

National Survey of the Health and Development of Children.—As reported last year, an enquiry into the growth, health, and development of children is being carried out by the Joint Committee of the Institute of Child Health (University of London), the Society of Medical Officers of Health, and the Population Investigation Committee. Through the Maternity and Child Welfare Services, some 6,000 children born in England, Wales, and Scotland between 3rd and 9th March, 1946, have been followed up during the first five years of their lives, and a unique amount of information has been collected on their home conditions, their illnesses, accidents, growth, and development. The children are drawn from all social classes, and their experiences will, it is hoped, give an unbiased picture of the health and environment of all children in Great Britain. These children now attend school, and the work will be continued during their school lives. The survey children are examined yearly by the school medical officers in March, when the health visitors also obtain additional information required for the enquiry. Records of absences from school are kept by the head teachers, and the health visitors are responsible for recording any illnesses which occur during vacations. Aberdeen's quota of the children concerned is 14 children.

F. CO-OPERATION WITH TEACHERS AND PARENTS.

It is pleasant to record that the relations of the school health service and the teaching staff are in general cordial and mutually helpful. Most teachers are very ready to co-operate in any measures taken for improving the health of the children under their care. In many schools, the school medical officers and health visitors are frequently consulted by the teachers on aspects of the health education curriculum, which continues to be a feature of class education from the five-year-old stage onwards. Nevertheless, there is need for even more co-operation in the future, and there are certainly some schools in which the teachers do not yet appear to appreciate that the school health visitor is a highly trained professional officer whose expert advice on health matters is constantly available.

The attendance of parents at the routine medical inspections is satisfactorily high, but naturally varies according to the age-group being examined. A total of 97·1 per cent of the parents of the five-year-old children was present when their children were inspected, 89·4 per cent. at the inspection of the nine-year-olds, 65·2 per cent. at the inspection of the thirteen-year-olds, and 27·6 per cent. at the inspection of the sixteen-year-olds, giving an overall percentage of 83·1 per cent. The scheme of medical inspection is now completely accepted as part of the school routine, and parents of children in the older age-groups are generally content to allow their children to come unattended unless there is some known or suspected defect about which they desire advice. The attendance of 29 parents for every 30 entrants and of 9 parents for every 10 children aged nine years is particularly gratifying. Advantage is taken as much as possible of the attendance of the parents at these inspections to instil principles of health education in both parent and child and to inculcate the idea of maintenance of health as part of one's duty to oneself and to

the community. Talks are also occasionally given by the school medical and nursing staff to meetings of parent-teacher associations connected with some of the schools, and (although the usefulness of these talks is probably limited because usually the parents to whom one most desires to talk are not present) these talks undoubtedly play a part in disseminating knowledge of the principles of healthy living.

THE FINDINGS OF MEDICAL INSPECTION.

General.

Systematic medical inspection was carried out in the four age-groups prescribed—(1) entrants, (2) children aged 9 years, (3) children aged 13 years, and (4) children aged 16 years. Since it is not usually practicable, without undue expenditure of time, to examine the vision and hearing of children entering school for the first time, vision- and hearing-testing was carried out in the case of the 7-year-old children. In addition (as already mentioned), a rapid inspection was made of 5-year-old children soon after school entry.

In all, four hundred and ten visits were paid to schools by the medical officers in connection with systematic medical inspection, and before each inspection a good deal of preparatory work was done—*e.g.*, the weighing, measuring, sight-testing, and hearing-testing of the children.

Preliminary Inspection of "Entrants."

The preliminary rapid review of all school entrants for detection of obvious physical defects and verminous conditions revealed the following details:—

Total number inspected	2,790
Dirty heads—Nits	65 or 2·3 per cent.
Vermin	6 or 0·2 per cent.
Squints	125 or 4·4 per cent.
Other diseases	33 or 1·2 per cent.
Number excluded for various infections	7 or 0·3 per cent.
Unsatisfactory clothing	3 or 0·1 per cent.

As compared with the previous year, the proportions with dirty heads and with unsatisfactory clothing are unchanged, and there are decreases in the numbers with squint, infections, and other diseases.

Systematic Medical Examination.

Details of the number and percentage of individual children in each age-group found to be suffering from particular defects are given in Table II at the end of this section of the Report. A summary is presented here:—

Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.	Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.
1. Clothing unsatisfactory	8,267	6	.07	9. Ears—			
2. Footgear unsatisfactory	"	8	.1	(a) Diseases:			
3. Cleanliness—				Otorrhœa	8,267	95	1.1
(a) Head: Nits	"	17	.2	Other diseases	"	141	1.7
Vermin	"	6	.07	(b) Defective hearing:			
(b) Body: Dirty	"	1	.01	Grade I	5,000	31	.6
Vermin	"	—	—	Grade IIa	"	5	.1
4. Skin—				Grade IIb	"	—	—
(a) Head: Ringworm	"	—	—	Grade III	"	—	—
Impetigo	"	37	.4	10. Speech—			
Other diseases	"	34	.4	Defective articulation	8,267	61	.7
(b) Body: Ringworm	"	2	.02	Stammering	"	9	.1
Impetigo	"	—	—	11. Mental and Nervous Condi-			
Scabies	"	5	.06	tion—			
Other diseases	"	215	2.6	(a) Backward	"	14	.2
5. Nutritional State—				(b) Dull	"	2	.02
Slightly defective	"	204	2.5	(c) Mentally deficient (educable)	"	1	.01
Bad	"	1	.01	(d) Do. (ineducable)	"	—	—
6. Mouth and teeth unhealthy	"	298	3.6	(e) Highly nervous or unstable	"	25	.3
7. Naso-pharynx—				(f) Difficult in behaviour	"	17	.2
(a) Nose:				12. Circulatory System—			
(i) Obstruction requiring				(a) Organic heart disease:			
observation	"	653	7.9	(i) Congenital	"	23	.3
(ii) Obstruction requiring				(ii) Acquired	"	10	.1
operative treatment	"	20	.2	(b) Functional conditions	"	52	.6
(iii) Other conditions	"	7	.08	13. Lungs—			
(b) Throat:				Chronic bronchitis	"	17	.2
(i) Tonsils requiring obser-				Suspected tuberculosis	"	30	.4
vation	"	1,284	15.5	Other diseases	"	204	2.5
(ii) Tonsils requiring oper-				14. Deformities—			
ative treatment	"	75	.9	(a) Congenital	"	37	.4
(c) Glands:				(b) Acquired (infantile para-			
(i) Requiring observation	"	411	5.0	lysis)	"	21	.3
(ii) Requiring operative				(c) Acquired (probably rickets)	"	111	1.3
treatment	"	4	.05	(d) Acquired (other causes)	"	193	2.3
8. Eyes—				15. Infectious disease	"	8	.1
(a) External diseases:				16. Other diseases or defects	"	837	10.1
Blepharitis	"	105	1.3	17. Classification:			
Conjunctivitis	"	8	.1	Group I	"	3,177	38.4
Corneal opacities	"	3	.04	Group IIa	5,000	572	11.4
Strabismus	"	380	4.6	Group IIb	8,267	123	1.5
Other diseases	"	68	.8	Group IIc	5,000	10	.2
(b) Visual acuity with/without				Group III	8,267	3,530	42.7
glasses:				Group IVa	"	631	7.6
Fair	5,000	926	18.5	Group IVb	"	224	2.7
Bad	"	73	1.5	Number notified to parents as			
Recommended for refraction	"	392	7.8	suffering from defects	"	693	8.4
				Number under observation	"	3,922	47.4
				Number of parents present at			
				inspection (6,870)	"	—	83.1
				Number wearing glasses	"	738	8.9

While some of these figures show only the usual slight differences from year to year, it is satisfactory to note that the number of children with dirty heads continues to decrease sharply, that there is a decline in the small number with unsatisfactory clothing or footwear, that ringworm has virtually disappeared, that impetigo remains something of a rarity, and that heart and lung conditions are more infrequent than in the past. The most disquieting features of the table are the apparent continued increase in the prevalence of squint and the substantial increase in the figures for defective nutrition.

Analysis of the figures for squint by age-groups reveals that the apparent increase is really in the older age-groups, and is in fact a continuation of the high figures found in entrants some years ago. In children aged five years, there is actually a decrease in the amount of squint. Here are the percentages for the last ten years:—

	1944-5.	1945-6.	1946-7.	1947-8.	1948-9.	1949-50	1950-1.	1951-2.	1952-3.	1953-4.
Entrants . . .	3.5	5.3	7.1	9.7	9.8	9.0	7.0	7.2	6.7	6.4
All children . .	3.6	3.8	4.2	5.3	5.0	5.1	5.0	5.1	4.3	4.6

The slight decrease in the incidence of squint in school entrants is probably related to the progress of the Corporation's housing programme. (For fuller discussion of the relationship between squint and overcrowding, established by a special enquiry in 1953, reference may be made to page 73 of last year's report.)

The substantial increase in the figures for defective nutrition (from 0.3 per cent. in 1952-53 to 2.5 per cent. in 1953-54) is sufficiently serious to demand further consideration. (See below.)

The percentage of children notified to parents as suffering from defects (8.4) is very similar to that in previous years, as is the percentage of children requiring to be kept under observation by the nurses (47.4). The proportion of parents present at examination (83.1 per cent.) is the highest yet recorded.

Nutrition of Children.

In 1951 to 1952, 0.2 per cent. of school children were found at examination to be inadequately nourished. In 1952 to 1953, the percentage was 0.3, and in 1953 to 1954, 2.5. The actual number of defectively nourished children in these years was 18, 24, and 205, respectively.

There are several possible explanations of an apparent increase in the amount of defective nutrition. For example, the explanation might be (*a*) that there is a genuine serious rise in the amount of defective nutrition, or (*b*) that a new medical officer has employed in respect of nutritional adequacy standards a shade stricter than those used by the other medical officers, or (*c*) that a medical officer previously on the staff has adopted stricter standards than in the past, or (*d*) that a combination of these explanations applies. To approach the truth, a few rough tests can be applied.

(1) Analysis by age-group.

If the increase is genuine, then one would expect to find that it was most marked in entrants, since they have not previously had the advantage of school meals.

Division into age-groups shows that 4.2 per cent. of entrants were under-nourished (as compared with 0.15 per cent. in the previous year). In no other age-group was the percentage higher than 1.6. This predominance in the 5-year-old age-group would be in favour of the increase being genuine.

(2) *Analysis by situation of school.*

If the increase is genuine, one would expect it to occur mainly in new housing areas, where the re-housed occupants are faced with the financial problems of higher rents and of the cost of travelling to work, &c. The largest numbers of malnourished children were found in such schools as Cummings Park, Marchburn, and Westerton, which again might be evidence in favour of the increase being real.

(3) *Analysis by school medical officer.*

If the increase is due to a variation in standards, one would expect that it would be confined to schools examined by a particular doctor. Analysis reveals that there are considerably more cases of alleged mal-nutrition in children inspected by one medical officer than in those inspected by the other medical officers.

The evidence so far is inconclusive and would, on the whole, suggest that there were two factors operating, namely, both an increase in subnormal nutrition and an alteration in standards. It is, however, possible to apply a fourth test, namely, comparison of body weights. If the increase in alleged mal-nutrition is in fact unreal, then one would expect to find no diminution of average body weights in the group most affected, *i.e.*, school entrants. If, on the other hand, the increase in alleged mal-nutrition is a genuine one, then it might be anticipated that there would be a slight decline in the average weights of school entrants, *i.e.*, the group that had not yet for long received the benefit of school meals.

An analysis of the weights of boys and girls aged 5½ years for a period of successive years is as follows:—

	Boys.	Girls.
1948-49 . . .	42.4 lbs.	41.1 lbs.
1949-50 . . .	42.8 lbs.	40.7 lbs.
1950-51 . . .	42.8 lbs.	41.0 lbs.
1951-52 . . .	42.9 lbs.	40.8 lbs.
1952-53 . . .	42.4 lbs.	40.5 lbs.
1953-54 . . .	42.1 lbs.	40.8 lbs.

One expects, of course, slight variations from year to year due to pure chance, but, if these variations are minimised by combining the years in pairs, one gets the following:—

	Boys.	Girls.
1948-50 . . .	42.6 lbs.	40.9 lbs.
1950-52 . . .	42.85 lbs.	40.9 lbs.
1952-54 . . .	42.25 lbs.	40.65 lbs.

Although part of the explanation of the apparent increase in subnormal nutrition may lie in an alteration of standards, the evidence of body weights helps to confirm that, to some extent, the increase in subnormal nutrition is a real one.

Classification on routine examination.

Figures for 1953-54 and percentages for the last four years are given below:—

Classification.	1953-54.		1952-53.		1951-52.		1950-51.	
	No.	%	No.	%	No.	%	No.	%
I. Free from defects	3,177	38.4	3,674	36.4	3,119	31.9	3,758	37.5
*IIA. Defective vision but otherwise free from defects	572	11.4	974	9.4	1,010	10.0	1,119	11.9
IIB. Mouth and teeth unhealthy but otherwise free from defects	123	1.5	111	1.1	112	1.2	108	0.8
*IIC. Combination of IIA and IIB	10	0.2	102	0.2	102	0.2	101	0.1
III. Children with ailments from which recovery is expected in a few weeks	3,530	42.7	4,811	48.1	4,977	49.7	4,319	43.9
IV. Children with more serious defects—								
(a) Where cure is considered possible	631	7.6	615	6.5	811	8.1	612	6.2
(b) Where only improvement is considered possible	224	2.7	211	2.1	311	3.1	315	3.5

* Percentage with eye defects refers to children receiving visual tests, *i.e.*, a different total from number having routine medical overhauls. Hence the percentage when added will not come to exactly 100.

HEIGHTS AND WEIGHTS OF CHILDREN EXAMINED.

The following table gives particulars of the heights and weights of children examined. The small figure in the age column refers to months: thus 5³ means 5 years 3 months.

Age Group (years).	BOYS				GIRLS			
	Number Examined.	Average Age.	Average Height in Inches.	Average Weight in Pounds.	Number Examined.	Average Age.	Average Height in Inches.	Average Weight in Pounds.
5—6	1,342	5 ³	42.3	42.1	1,213	5 ³	42.0	40.8
9—10	1,184	9 ⁴	51.5	63.9	1,095	9 ⁴	50.8	61.5
13—14	1,235	13 ⁵	59.6	93.7	1,128	13 ⁵	59.7	97.0
16—17	160	16 ⁶	67.7	133.6	146	16 ⁶	63.8	123.2

For comparison with previous years, reference should be made to Table V at the end of the report.

RE-INSPECTION.

Re-inspection includes the re-examination of children who have had defects discovered at routine medical examinations during the year and for whom treatment had been advised; it also includes certain children who were placed under observation because it was suspected that they might be suffering from some ailment,

The total number of children re-inspected was 5,410 (as compared with 2,643 in 1952-53). Details of re-inspections are as follows:—

	Number Re-examined.	Treatment Completed.	2nd Notice.	Number Improved but kept under Observation.
Dirty heads	75	29	17	29
Defective vision	666	418	106	142
Enlarged tonsils	277	115	96	66
Skin diseases	3	3	—	—
Scabies	1	—	1	—
Other diseases	143	51	85	7
Number under observation .	6,009	3,325	—	2,684
Total	7,174	3,941	305	2,928

It will be observed that it is stated that 5,410 represents the total number of children re-inspected, whereas in the table the number of re-inspections is given as 7,174. The difference is due to the fact that some of the children examined had more than one defect.

OTHER EXAMINATIONS.

(1) *Visits by School Medical Officers.*

These are visits for the supervision of hygienic conditions, the investigation of outbreaks of infectious disease, the study of various influences affecting the physical and mental well-being of the children, and the examination of mentally-handicapped children. During the year, 231 such visits were paid by the medical officers (as compared with 162 in 1952-53).

(2) *Unannounced Visits by Health Visitors.*

These visits are of supreme importance both for the detection of early deviations from normality and for the promotion of health. Ideally, the health visitors should inspect every child each term (with the possible exception of children who are receiving a routine medical overhaul during that term) and selected children at more frequent intervals. As in previous years, however, the available staff was numerically insufficient for this purpose, but practically every child was inspected at least once during the year, and the majority of children were inspected twice.

Since the number of hygiene inspections was small, an excessive prominence may in the past have been given to "cleanliness" which, of course, must never be neglected. Nowadays, at least equal emphasis is placed by the health visitors on such matters as nutrition, fatigue, posture, debility, and nervousness; but (to permit of comparison with past years) these are grouped here under the heading of "other diseases":—

Total number of ordinary inspections	55,241
Total number of inspections showing live vermin of head	214
" " " " " nits in hair	1,809
" " " " " impetigo	71
" " " " " scabies	1
" " " " " other diseases	2,873
" " " " " unsatisfactory clothing	508
" " " " " unsatisfactory footwear	211

It is interesting to note that the figure for "other diseases" is more than five times as high as in 1952-53 and more than twenty-seven times as high as in 1951-52—an indication not of more disease but of more thorough examination.

In addition, the health visitors examined 13,424 "selected" cases, many of whom had previously been found to have some defect of cleanliness. (This figure may be compared with 6,408 in the previous year.) Of these, 207 (or 1.5 per cent.) were found to have live head vermin, and 1,997 (or 14.1 per cent.) to have nits of the hair.

(3) *Home Visits by Health Visitors.*

As already mentioned, these visits are among the most important aspects of the school health service, and enable the visiting nurse to act as a link between home and school, to the benefit of both. Unfortunately, the visits are also time-consuming, and shortage of staff prevented an adequate number of visits from being paid.

Health visitors paid 2,264 visits (as compared with 1,753 in 1952-53) to homes to give advice about school children. As a result of their visits they reported 421 children as being "slightly improved," 224 as "markedly improved," and 68 as "cured."

(4) *Examination of vision of seven-year-old children.*

During the year 2,739 children born in 1946 had their vision tested, and 215 were referred to the school eye clinic for refraction.

(5) *Examination for Tertowie Residential School.*

During the year, 344 pupils (149 boys and 195 girls) from junior secondary schools were inspected before departure for a three weeks' period at Tertowie Residential School. Because of the length of time away from Aberdeen, a very strict standard of examination was required, but only 3 pupils had to be excluded as unfit.

(6) *Mental Assessment.*

73 children suspected of being educationally subnormal were examined (as compared with 107 in the previous year when the waiting list for mental assessment was cleared off). Of these 73, 40 were recommended for admission to the Special School, and 21 for admission to special classes in ordinary schools, while decision was temporarily delayed in 12 cases. All children referred for mental examination before 30th June had been examined by the end of the school year.

In addition, a start was made with the biennial re-testing of children admitted to the Special School, 39 children being re-tested during the year; 10 children admitted to Polmuir Road School for the Deaf had their intelligence tested by special methods; and 31 children previously reported as ineducable but still remaining at home were visited with a view to occupational centre training.

An interesting development was the referral to this department by infant mistresses of 14 children under the age of 7 years.

(7) *Audiometric Examination of Seven-year-old and other Children.*

Systematic audiometric testing for the early and scientific detection of hearing defects which was commenced last year was continued during the year under review. The children tested were those born in the years 1946, 1944 and 1943, and also children of other ages who were suspected of having some degree of deafness by the teachers or health visitors. The method used was again the "sweep" method at 15 decibels of hearing loss by use of the pure-tone audiometer.

The classification of those found to have a hearing loss was the same as was described last year, and the cases of apparent defective hearing were followed up medically (including the use of the auriscope). In cases where there was no obvious temporary cause or where it was thought that a hearing-aid might be necessary, children were referred to the Ear, Nose and Throat Department of the Royal Aberdeen Hospital for Sick Children.

Deafness is normally classified into four grades: Grade I—slightly hard of hearing; Grade IIa—requiring favourable position in class and may need a hearing-aid; Grade IIb—often needing to be taught in a special class by special methods; and Grade III—requiring to be taught in a school for the deaf.

The results of the work done during the year are as follows:—

Group I—		Number Tested.	Normal.	Defective.
All children born in 1946	.	2,820	2,713	107
" " " " 1944	.	2,173	2,078	95
" " " " 1943	.	2,217	2,130	87
Group II—				
Children of other ages suspected of deafness		451	198	253

CLASSIFICATION OF CHILDREN WITH DEFECTIVE HEARING.

	DEAF IN ONE EAR.		BOTH EARS AFFECTED.				
	Normal/1	Normal/2A	1	1/2A	2A	2B	3
GROUP I—							
Born 1946	60	10	23	1	8	—	—
" 1944	54	8	17	1	7	—	—
" 1943	58	6	24	3	4	—	—
GROUP II—							
Other ages	97	19	102	8	27	—	—

NUMBER OF CHILDREN REFERRED FOR INVESTIGATION AND/OR TREATMENT AFTER EXAMINATION BY SCHOOL MEDICAL OFFICERS.

	Group I		Group II	
	1946.	1944.	1945.	Other Ages.
Number referred to Hospital for Sick Children	1	1	6	14
Number referred to School Ear, Nose and Throat Clinic	4	14	10	35
Number referred to own doctor	10	7	20	36
Number where no action was necessary	26	59	55	124
Number absent	2	6	4	25
Number awaiting examination by school medical officers	64	—	—	19

In addition to the foregoing, children from all the Special Schools were tested (308 children from the Rubislaw-Ruthrieston-Raeden Group and 69 from Polmuir Road School). The classification of hearing defects was as follows:—

SCHOOL.	DEAF IN ONE EAR.		BOTH EARS AFFECTED.				
	Normal/1	Normal/2A	1	1/2A	2A	2B	3
Rubislaw	12	5	12	—	9	—	—
Ruthrieston							
Raeden							
Polmuir Road							
	—	—	—	—	—	20	49

MEDICAL TREATMENT.

A—MINOR AILMENTS, SKIN DISEASES, &c.

(1) *Cuts, Bruises, Sprains, Minor Injuries, &c.*

Cases occurring in schools while any of the medical or nursing staff are in the school are dealt with by them, but many cases are given first-aid treatment by the teaching staff, many of whom have had first-aid training. Children requiring further treatment are referred to their own doctor or, in serious cases (*e.g.*, fractures) to the Casualty Departments of the General Hospitals. No information is at present available about the number of children in this group who have received treatment by their own medical attendant or at any of the hospitals.

(2) *Attendance (Minor Ailments) Clinics.*

These clinics are held at Powis Junior Secondary School on Thursdays at 9.30 a.m., and at the Child Welfare Centre, Castlegate, on Thursdays at 2 p.m., and also at the Dispensary Buildings, Guestrow, on Mondays at 4 p.m. Children are referred from various sources, such as health visitors, school welfare officers, and head teachers. During the year, 1,492 children were referred, and made 1,670 attendances.

(3) *Diseases of the Ear, Nose, and Throat.*

The Ear, Nose, and Throat Clinic is held at Dispensary Buildings, Guestrow, on alternate Fridays at 2 p.m. A health visitor is in attendance daily at 4 p.m. to give treatment where necessary. The attendances during the school year 1953-54 were as follows:—

Number of new cases	67
Number referred to hospital	10
Number referred to own doctor . . .	4
Number treated at clinic	31
Number discharged requiring no treatment	22
Total attendances at clinic	1,194
Number discharged cured	35

About 85 per cent. of the new cases are cases of diseases of the ear alone.

The vast majority of cases of enlarged tonsils and adenoids are not referred to the Ear, Nose, and Throat Clinic but are referred to the family doctor in the first instance.

(4) *Diseases of the Eye, excluding Defective Vision.*

These cases continue to be referred, by arrangement, to the Eye Institution, 142, King Street, Aberdeen. The number of cases so referred was 18 of epidemic conjunctivitis and 6 of severe blepharitis.

(5) *Diseases of the Skin.*

Only one case of ringworm of the scalp and 11 cases of ringworm of the body were found and treated. The virtual disappearance of ringworm in the last few years is worth noting. Most cases of ringworm are referred, by arrangement, for treatment at the Skin Out-Patient Department, Aberdeen Royal Infirmary, Woolmanhill.

With regard to impetigo, 234 children were treated at the School Skin Clinic, Dispensary Buildings, Guestrow, Aberdeen; 2,059 attendances were involved. (The figures for the previous year were 95 children and 627 attendances). These figures show that, since Autumn, 1953, there has been a real increase in the prevalence of impetigo contagiosa, the figures for which have been low for some years preceding this year. It is possible that the bacteria which cause this disease have become rather more virulent.

As for scabies, cases are usually referred for treatment to the Cleansing Station at the City Hospital, along with all contacts, adults as well as children. Eight families, of whom one or more school-child members of the family were found to be suffering from scabies, were so dealt with, involving a total of 4 adults, 18 school children, and 6 children under school age. These figures are lower than the corresponding figures for 1952-53, and are the lowest for this particular disease ever recorded in Aberdeen.

The numbers of children known to the department to have been treated for the undernoted skin ailments at the Skin Out-Patient Departments of the hospitals were as follows:—

Acne	6	Molluscum-contagiosum	4
Dermatitis	1	Verrucosis	1
Eczema	2	Warts	77

B—DEFECTIVE VISION AND SQUINT.

As a result of vision testing in schools, 2,438 children (1,209 boys and 1,229 girls) were examined by eye specialists employed by the North-Eastern Regional Hospital Board. The eye clinic was held at Dispensary Buildings, Guestrow, on Mondays, Wednesdays, Thursdays, and Fridays at 2 p.m. Spectacles were prescribed in all necessary cases.

In addition to the 2,438 children mentioned above, 134 pre-school children were also examined at the clinic. These figures compare with 2,504 school children and 117 pre-school children in the previous year.

During the year, the Corporation decided to employ an orthoptist for the more adequate treatment of squint.

C—NOSE AND THROAT (OPERATIVE TREATMENT).

Cases which appear to require operative treatment are, in general, referred in the first instance to the family doctor.

D—ORTHOPÆDIC AND POSTURAL DEFECTS (SPECIALIST TREATMENT).

The Orthopædic Clinic, controlled by the North-Eastern Regional Hospital Board has, since October, 1952, been held at Dunfermline College of Physical Education, Old Infirmary Buildings, Woolmanhill. This change was made at the suggestion of the authorities of the College of Physical Education, and continues to be mutually helpful to both parties in as much as the schools were finding it increasingly difficult to carry out special remedial exercises for postural defects, &c., and the College is assured of suitable cases for demonstration and teaching purposes. The clinics are held at intervals of approximately one month according to the number of cases to be examined, and are still conducted by one of the orthopædic surgeons of Aberdeen Royal Infirmary.

During the year, 62 children were examined by the orthopædic surgeons, and 6 of these were referred to one or other of the general hospitals for further investigation and treatment in hospital; special remedial exercises were recommended for 17; and no action, further than the slight raising of soles and heels of shoes in some cases, was considered necessary in the case of 39 children.

In addition to the above-mentioned cases, 97 children who had previously been attended at the clinic paid re-visits for ascertainment of the progress of the prescribed treatment.

E—SPEECH DEFECTS.

The School Health Service continued to co-operate with the Speech Therapy Department in referring appropriate cases to that department. Patients treated during the year included 40 from special schools and 329 from ordinary schools.

F—CHILD GUIDANCE.

Until 1953, the work of the child-guidance clinic was handicapped by the fact that, owing to shortage of school medical officers, no doctor was available for the physical assessment of children referred there. During almost the whole of 1953-54, however, a medical officer has been present at the clinic for one session each week. Children attending the clinic have been examined, and some have been found to require special medical treatment.

DENTAL INSPECTION AND TREATMENT.

Inspection.

In all, forty sessions were devoted to dental inspection of children in schools (as compared with 39 sessions in 1952-53, 34 sessions in 1951-52, and 2 sessions in 1950-51). The age distribution and details are as follows:—

Year of Birth.	Number Inspected.	Number requiring Treatment.			Number of Acceptances.
1940 . .	638	...	547	...	287
1941 . .	580	...	488	...	297
1943 . .	537	...	435	...	209
1944 . .	260	...	228	...	122
1945 . .	976	...	892	...	551
1946 . .	1,256	...	1,152	...	712
1947 . .	537	...	485	...	312
1948 . .	69	...	57	...	36
Totals . .	4,853	...	4,284	...	2,526

It is, of course, very disturbing that less than one-sixth of all children should be inspected in a year, especially when it is realised that over 88 per cent. of children examined were found to need treatment.

Treatment.

1,706 sessions were devoted to treatment (as compared with 1,660 in 1952-53, 1,415 in 1951-52, and 708 in 1950-51). As will be seen in the above table, of the 4,853 children dentally inspected in school, 4,284 (or 88 per cent.) were found to require treatment, and, of these, 2,526 (or 59 per cent.) intimated acceptance of treatment at the school clinic; 443 intimated that their children were being privately treated; and refusals numbered 1,315, this being the number of unsigned cards returned at the time of the dental inspections. A certain number of these cases ask for treatment later, but are then classified as emergency cases. It is interesting to note that the number of these emergency cases rose from 74 in 1952-53 to 230 during the present year.

Figures for the number of treatments given are recorded below:—

	Systematic (routine) Cases.	Special and Emergency Cases.
Number of children actually treated by the school dental officers	2,347	230
Number of attendances made by children for treatment . .	9,295	621
Fillings—		
(a) Permanent teeth	5,617	263
(b) Temporary teeth	355	4
Extractions—		
(a) Permanent teeth	847	114
(b) Temporary teeth	2,171	181
Anæsthetics—		
Number of administrations of a general anæsthetic for extractions	770	41
Number of local anæsthetics	608	162
Other operations—		
(a) Permanent Teeth	2,665	251
(b) Temporary teeth	744	28
Orthodontics—		
Number of regulations	12	
Part dentures	37	
Crowns	1	

The following work was performed at the School Dental Clinic in respect of children of pre-school age:—

Number of cases treated	18
Number of visits required	42
Extractions	35
Anæsthetics—	
General	12
Local	5
Fillings	6

IMMUNISATION.

(a) *Diphtheria Immunisation.*

The annual campaign of immunisation against diphtheria—mainly reinforcing doses among the five-year-old “entrants” and the eight-year-olds—was completed during the summer term. The following figures show the work done during the campaign. The corresponding figures for the last three years are given for comparison.

	1954.	1953.	1952.	1951.
Total number of visits paid to schools	101	88	93	86
Number of school children fully immunised for the first time (<i>i.e.</i> , two injections)	661	1,006	974	837
Number of school children who have received a reinforcing injection	3,714	3,904	3,685	3,051

The satisfactory response to the offer of a reinforcing injection continues to be encouraging. The number receiving initial (primary) immunisation will, of course, ultimately decline (as it is already beginning to do) as a result of most children securing primary immunisation before reaching school age.

At the end of June, 1954, 26,598 children of school age (or 94·8 per cent. of all children attending Infant, Primary, and Secondary Schools) had been immunised at some time.

(b) *Immunisation against Tuberculosis.*

As reported in the Annual Report for 1952-53, an attempt to offer protection to school children was commenced on 13th April, 1953, and in the summer of 1953. 3,274 pupils were tested, and 592 (who were found to be susceptible) were inoculated with B.C.G. vaccine. The campaign was eminently successful: indeed, its success may have played a part in inducing the Department of Health for Scotland to issue a circular commending B.C.G. to local health authorities.

Difficulty of follow-up during the holiday season made it seem desirable that subsequent campaigns be conducted in the autumn. Hence, no campaign took place during the school year under review, although at the end of the year arrangements were in hand for the 1954 campaign.

ARRANGEMENTS FOR PHYSICAL EDUCATION AND PHYSICAL HYGIENE.

The following information is presented by courtesy of Mr. T. S. Fairley, Superintendent of Physical Education.

Staffing.

The Physical Education staff consists of twenty-four female and seventeen male teachers. On the female staff, nine are attached to secondary schools, while the remaining fifteen are employed part-time in secondary, primary, and special schools. Nine male teachers are employed full-time in secondary schools, the remaining eight being engaged in primary and post-primary schools.

There are also four accompanists and one teacher of swimming.

Schools.

Previous reports contained complete and detailed information concerning the organisation of the subject and the introduction of new schemes of work for primary and secondary schools. No further developments of importance have taken place during the session under review.

During the past three years a transitionary period has ensued while the new schemes of work incorporating new contents and methods have been devised and tried out. During this period, too, teachers have become familiar with an entirely new approach to the subject and with new methods of presentation. This period of transition has now passed, and, while a certain degree of experimentation must continue, a more stable condition now prevails with regard to lesson format and content.

Assistance is given to all class teachers by specialists, who visit schools each week and give demonstration lessons.

In secondary schools, the work is carried out entirely by the teachers of physical education.

In addition, students from the College of Physical Education attend most of the schools for teaching practice.

Accommodation.

While most primary schools are provided with suitable indoor accommodation for the practice of physical exercises, suitable changing rooms are not always available. In such cases, children are required to change either in the hall or classrooms. It is gratifying to note, however, that in some of the newer schools this omission is being remedied.

All secondary schools are provided with fully equipped gymnasias and, except in the case of Middle and Rosemount, with the necessary ancillary accommodation. With the reconstruction of Rosemount, which is now in progress, a new gymnasium, with suitable changing and bathing facilities will be built,

Treatment of Physical Defects.

The remedial clinic, opened last session at the College of Physical Education, continues to function satisfactorily. During the past year, 35 children received treatment for a variety of physical defects, while a new venture—classes for pre-school children—has proved very successful. Some 20-25 children, aged 2 years to 4 years, attended the clinic with their parents twice weekly.

Playing-fields.

With the opening of Powis playing-field at the beginning of the session, the amount of ground available for the playing of organised games was substantially increased. In addition to its use during school hours, the new ground has proved a boon during Saturdays and in the evenings during spring and summer terms for the playing of inter-school games. Young children in the district have also found it a safe and pleasant refuge in which to play after school.

In addition to the official playing-fields, other accommodation was provided for use during school hours at Queen's Links, Seaton, and Stewart Park, while a number of schools made use of ground adjacent to the schools.

Games.

While the traditional team games occupy a prominent place in the curriculum, minor games and skills also play an important part in the scheme. These games and practices serve not only as a useful "lead up" to, as well as a supplement to, the more highly organised team games but also provide opportunities which encourage weaker children to take a more active part in the lesson and ensure that all the children enjoy the benefits of progressive training.

The usual inter-school competitions in football, cricket, and netball were held outwith school hours. These competitions aroused much enthusiasm, and the majority of schools entered teams.

Swimming.

The usual classes for beginners were held in the Middle School pond. In addition, arrangements were made for instruction in life-saving to be given to pupils who could already swim and who had gained the Committee's elementary certificate; 620 pupils attended these classes each week.

Similar classes for beginners were also organised at the Corporation pond from October to March, where the weekly attendance numbered 650 pupils.

The satisfactory progress made in both categories—beginners and swimmers—is shown by the standard achieved after various tests. Of the beginners, some 70 per cent. were able to swim on completion of the courses, while 980 swimmers gained elementary certificates. 101 pupils were awarded advanced certificates. In addition, 140 candidates were successful in gaining various awards of the Royal Life-saving Society.

The practical value accruing from sound swimming instruction was once again emphasised when Stephen Habster Fraser, a local young man, was awarded the

Royal Humane Society parchment for rescuing a boy from drowning in the River Dee. This young Kaimhill former pupil received all his swimming training in the Middle School pond.

Hanover Street Spray Baths.

Bathing facilities at Hanover Street spray baths were provided for pupils from nine schools. During the session under review, 15,000 attendances were recorded.

OTHER ACTIVITIES IN RELATION TO SCHOOL CHILDREN.

(a) *Linn Moor Convalescent Home, Culter.*

During the year, 71 children (34 boys and 37 girls) were sent to this Home, as compared with 66 in the previous year.

(b) *School Holiday Camps, 1954.*

During the months of June and July, the School Medical Officers visited all the junior secondary schools and five primary schools for the purpose of inspecting batches of children who proposed going to the holiday camps. Each batch was inspected twice. Of 1,044 children finally examined, only 4 girls had to be rejected because of unclean heads, and 1 because of failure to attend final inspection. This compares with the figures for the corresponding period last year of 946 children examined, 2 failures because of unclean heads and 11 because of absence.

(c) *Junior Club Camps, 1954.*

Visits of inspection were also paid in July to some primary schools for those younger children who belong to the appropriate junior clubs. In all, 197 children were finally examined. One boy had to be rejected because of an unclean head.

(d) *Senior Club Camps, 1954.*

Three hundred members of senior clubs were examined before going to various camps. All were fit to go to camp.

(e) *School Meals.*

The Director of Education has kindly supplied the following information about the School Meals Service. In all, there were 15 kitchens, including 5 nursery school kitchens. An average of 152 breakfasts were supplied each day. The price of a two-course lunch has remained at 8d. per meal during the year. Two-course lunches have been supplied daily during the year to an average of 5,600 pupils. This number remains exactly the same as it was after the price was increased from 6d. to 8d. last year, and is 700 less than the number immediately before the increase. Three-course lunches to the daily average number of 90 were supplied to pupils attending the Trades College.

(f) *Milk.*

The average number of bottles (one-third pint) of pasteurised milk supplied daily was 25,136.

TABLES.

The following tables are appended:—

- Table I. Numbers of children examined in the several age-groups.
 Table II. Return of number and percentage of individual children in each age-group suffering from particular defects.
 Table III. Classification of children examined at systematic medical examinations.
 Table IV. Return of all exceptional children of school age in the area.
 Table V. Average heights and weights—Years 1933-1954.

TABLE I.

Total number of children examined at—

(a) Systematic examinations—

Ordinary Schools—

Entrants	3,267
Second age-group	2,302
Third age-group	2,386
Fourth age-group	—

Secondary Schools—Age-group 312

8,267

(b) Other examinations—

Special cases	1,240
Re-inspections by Medical Officers	5,410

6,650

Number of individual children inspected at systematic examinations who were notified to parents as requiring treatment (excluding uncleanliness and dental caries):—

Entrants	200
Second age-group	239
Third age-group	238
Fourth age-group	—
Secondary age-group	16

693

TABLE
SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total Exam- ined. All ages.	ENTRANTS.			
		Boys 1,695		Girls 1,572	
1. Clothing unsatisfactory	8,267	1	·06	1	·06
2. Footgear unsatisfactory	"	1	·06	—	—
3. Cleanliness—					
(a) Head: Nits	"	—	—	6	·4
Vermin	"	1	·06	1	·06
(b) Body: Dirty	"	—	—	—	—
Vermin	"	—	—	—	—
4. Skin—					
(a) Head:					
Ringworm	"	—	—	—	—
Impetigo	"	14	·8	6	·4
Other Diseases	"	6	·4	2	·1
(b) Body:					
Ringworm	"	—	—	—	—
Impetigo	"	—	—	—	—
Scabies	"	2	·1	2	·1
Other Diseases	"	48	2·8	49	3·1
5. Nutritional state—					
Slightly defective	"	63	3·7	74	4·7
Bad	"	—	—	—	—
6. Mouth and Teeth Unhealthy	"	80	4·7	77	4·9
7. Naso-Pharynx—					
(a) Nose:					
(i) Obstruction requiring observation	"	187	11·0	135	8·6
(ii) Obstruction requiring Operative Treatment	"	10	·6	5	·3
(iii) Other Conditions	"	1	·06	—	—
(b) Throat:					
(i) Tonsils requiring observation	"	397	23·4	383	24·4
(ii) Tonsils requiring Operative Treatment	"	40	2·4	25	1·6
(c) Glands:					
(i) Requiring observation	"	147	8·7	118	7·5
(ii) Requiring Operative Treatment	"	—	—	4	·3
8. Eyes—					
(a) External Diseases:					
Blepharitis	"	14	·8	8	·5
Conjunctivitis	"	6	·4	—	—
Corneal Opacities	"	—	—	—	—
Squint	"	98	5·8	108	6·9
Other Diseases	"	11	·6	12	·8
(b) Visual Acuity (Snellen):					
Defective—Fair	5,000	—	—	—	—
Bad	"	—	—	—	—
Recommended for Refraction	"	43	2·5	47	3·0
Number wearing Glasses	8,267	42	2·5	44	2·8
9. Ears—					
(a) Diseases:					
Otorrhoea	"	29	1·7	20	1·3
Other Diseases	"	42	2·5	27	1·7

II.

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,191		Girls 1,111		Boys 1,245		Girls 1,141		Boys 162		Girls 150		Boys 4,293		Girls 3,974	
1	·08	1	·09	—	—	2	·2	—	—	—	—	2	·05	4	·1
1	·08	—	—	3	·2	3	·3	—	—	—	—	5	·1	3	·08
2	·2	5	·5	—	—	4	·4	—	—	—	—	2	·05	15	·4
1	·08	2	·2	—	—	1	·09	—	—	—	—	2	·05	4	·1
—	—	—	—	—	—	1	·09	—	—	—	—	—	—	1	·03
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
5	·4	9	·8	2	·2	1	·09	—	—	—	—	21	·5	16	·4
3	·3	2	·2	7	·6	8	·7	4	2·5	2	1·3	20	·5	14	·4
—	—	1	·09	1	·08	—	—	—	—	—	—	1	·02	1	·03
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	1	·09	—	—	—	—	—	—	—	—	2	·05	3	·08
25	2·1	26	2·3	27	2·2	29	2·5	3	1·9	8	5·3	103	2·4	112	2·8
14	1·2	22	2·0	21	1·7	10	·9	—	—	—	—	98	2·3	106	2·7
1	·08	—	—	—	—	—	—	—	—	—	—	1	·02	—	—
46	3·9	41	3·7	14	1·1	35	2·9	—	—	7	4·7	140	3·3	158	4·0
126	10·6	95	8·6	39	3·1	63	5·5	2	1·2	6	4·0	354	8·2	299	7·5
4	·3	—	—	—	—	1	·09	—	—	—	—	14	·3	6	·2
3	·3	—	—	2	·2	1	·09	—	—	—	—	6	·1	1	·03
157	13·2	177	15·9	35	2·8	122	10·7	2	1·2	11	7·3	591	13·8	693	17·4
5	·4	4	·4	—	—	1	·09	—	—	—	—	45	1·0	30	·8
49	4·1	46	1·1	23	1·8	24	2·1	2	1·2	2	1·3	221	5·1	190	4·8
—	—	—	—	—	—	—	—	—	—	—	—	—	—	4	·1
10	·8	26	2·3	13	1·0	32	2·8	—	—	2	1·3	37	·9	68	1·7
—	—	—	—	1	·08	1	·09	—	—	—	—	7	·2	1	·03
—	—	1	·09	1	·08	1	·09	—	—	—	—	1	·02	2	·05
55	4·6	57	5·1	32	2·6	29	2·5	1	·6	—	—	186	4·3	194	4·9
11	·9	14	1·3	5	·4	14	1·2	1	·6	—	—	28	·7	40	1·0
156	13·1	178	16·0	271	21·8	243	21·3	36	22·2	42	28·0	463	17·8	463	19·3
23	1·9	12	1·1	13	1·0	22	1·9	2	1·2	1	·7	38	1·5	35	1·5
89	7·5	83	7·5	84	6·7	123	10·8	5	3·1	8	5·3	178	6·9	214	8·9
110	9·2	131	11·8	181	14·5	169	14·8	30	18·5	31	20·7	363	8·5	375	9·4
15	1·3	10	·9	5	·4	14	1·2	1	·6	1	·7	50	1·2	45	1·1
20	1·7	29	2·6	9	·7	11	1·0	—	—	3	2·0	71	1·7	70	1·8

Return of number and percentage of individual children

NATURE OF DEFECT.	Total exam- ined. All ages.	ENTRANTS.			
		Boys 1,695		Girls 1,572	
9. Ears—(Continued)—					
(b) Defective Hearing :					
Grade I	5,000	8	·5	5	·3
Grade IIA	"	—	—	—	—
Grade IIB	"	—	—	—	—
Grade III	"	—	—	—	—
10. Speech—					
Defective articulation	8,267	27	1·6	14	·9
Stammering	"	2	·1	2	·1
11. Mental and Nervous Conditions—					
(a) Backward	"	2	·1	5	·3
(b) Dull	"	—	—	—	—
(c) Mentally deficient (Educable)	"	—	—	1	·06
(d) Mentally deficient (Ineducable)	"	—	—	—	—
(e) Highly nervous or unstable	"	5	·3	5	·3
(f) Difficult in behaviour	"	7	·4	4	·3
12. Circulatory System—					
(a) Organic heart disease :					
(i) Congenital	"	4	·2	7	·4
(ii) Acquired	"	1	·06	1	·06
(b) Functional conditions	"	19	1·1	17	1·1
13. Lungs—					
Chronic bronchitis	"	4	·2	3	·2
Suspected tuberculosis	"	7	·4	7	·4
Other diseases	"	60	3·5	51	3·2
14. Deformities—					
(a) Congenital	"	11	·6	11	·7
(b) Acquired (Infantile paralysis)	"	4	2	5	·3
(c) Acquired (Probably rickets)	"	32	1·9	24	1·5
(d) Acquired (Other causes)	"	39	2·3	34	2·2
15. Infectious diseases	"	3	·2	5	·3
16. Other diseases or defects	"	204	12·0	146	9·3
17. Classification :					
Group I	"	503	29·7	529	33·7
Group IIA	5,000	—	—	—	—
Group IIB	8,267	28	1·7	26	1·7
Group IIC	5,000	—	—	—	—
Group III	8,267	980	57·8	818	52·0
Group IVA	"	146	8·6	161	10·2
Group IVE	"	38	2·2	38	2·4
Number Notified to parents	"	107	6·3	93	5·9
Number under observation	"	1,025	60·5	930	59·2
Number of Parents present	"	1,646	97·1	1,526	97·1

II (Continued.)

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,191		Girls 1,111		Boys 1,245		Girls 1,141		Boys 162		Girls 150		Boys 4,293		Girls 3,974	
9 2	·8 ·2	10 2	·9 ·2	7 1	·6 ·08	4 —	·4 —	1 —	·6 —	— —	— —	17 3	·7 ·1	14 2	·6 ·08
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
10 1	·8 ·08	5 —	·5 —	1 4	·08 ·3	3 —	·3 —	— —	— —	1 —	·7 —	38 7	·9 ·2	23 2	·6 ·05
3 —	·3 —	2 —	·2 —	2 1	·2 ·08	— 1	— ·09	— —	— —	— —	— —	7 1	·2 ·02	7 1	·2 ·03
—	—	—	—	—	—	—	—	—	—	—	—	—	—	1 —	·03
5 2	·4 ·2	2 1	·2 ·09	3 2	·2 ·2	5 1	·4 ·09	— —	— —	— —	— —	13 11	·3 ·3	12 6	·3 ·2
2 —	·2 —	6 1	·5 ·09	— 3	— ·2	1 4	·09 ·4	1 —	·6 —	2 —	1·3 —	7 4	·2 ·09	16 6	·4 ·2
2 —	·2 —	3 —	·3 —	3 —	·2 —	7 —	·6 —	— —	— —	1 —	·7 —	24 —	·6 —	28 —	·7 —
2 7	·2 ·6	1 4	·09 ·4	6 —	·5 —	— 5	— ·4	1 —	·6 —	— —	— —	13 14	·3 ·3	4 16	·1 ·4
35	2·9	19	1·7	24	1·9	14	1·2	1	·6	—	—	120	2·8	84	2·1
3 5	·3 ·4	5 1	·5 ·09	3 3	·2 ·2	3 2	·3 ·2	1 1	·6 ·6	— —	— —	18 13	·4 ·3	19 8	·5 ·2
15 33	1·3 2·8	17 25	1·5 2·3	4 21	·3 1·7	18 33	1·6 2·9	— 3	— 1·9	1 5	·7 3·3	51 96	1·2 2·2	60 97	1·5 2·4
—	—	—	—	—	—	—	—	—	—	—	—	3	·07	5	·1
146	12·3	116	10·4	64	5·1	136	11·9	7	4·3	18	12·0	421	9·8	416	10·5
459	38·5	394	35·5	683	54·9	448	39·3	99	61·1	62	41·3	1,744	40·6	1,433	36·1
58	4·9	79	7·1	248	19·9	133	11·7	30	18·5	24	16·0	336	12·9	236	9·8
23	1·9	19	1·7	5	·4	18	1·6	—	—	4	2·7	56	1·3	67	1·7
4	·3	1	·09	3	·2	—	—	—	—	2	1·3	7	·3	3	·1
519	43·6	504	45·4	224	18·0	415	36·4	22	13·6	48	32·0	1,745	40·6	1,785	44·9
88	7·4	90	7·2	59	4·7	87	7·6	3	1·9	7	4·7	296	6·9	335	8·4
40	3·4	34	3·1	23	1·8	40	3·5	8	4·9	3	2·0	109	2·5	115	2·9
130	10·9	109	9·8	91	7·3	147	12·9	6	3·7	10	6·7	334	7·8	359	9·0
560	47·0	523	47·1	338	27·1	449	39·4	36	22·2	61	40·7	1,959	45·6	1,963	49·4
1,058	88·8	999	89·9	731	58·7	824	72·2	42	25·9	44	29·3	3,477	81·0	3,393	85·4

TABLE III.

SYSTEMATIC MEDICAL EXAMINATIONS.

CLASSIFICATION	ENTRANTS		SECOND AGE-GROUP		THIRD AGE-GROUP		FOURTH AGE-GROUP		TOTAL	
	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the children examined systematically at examinations
I. Children free from defects	1,052	31.6	853	37.1	1,131	47.4	161	51.6	3,177	38.4
II. Children (otherwise free from defects) who suffer from—										
(a) Defective vision not worse than 6/12 in the better eye with or without glasses	—	—	137	6.0	381	16.0	54	17.3	572	6.9
(b) Oral Sepsis, etc.	54	1.7	42	1.8	23	1.0	4	1.3	123	1.5
(c) Both (a) and (b)	—	—	5	0.2	3	0.1	2	0.6	10	0.1
Total	54	1.7	184	8.0	407	17.1	60	19.2	705	8.5
III. Children suffering from ailments (other than those mentioned in II.) from which complete recovery is anticipated within a few weeks	1,798	55.0	1,023	44.4	639	26.8	70	22.4	3,530	42.7
IV. Children suffering from (or suspected to be suffering from) defect less remediable than defects specified in II. and III., distinguishing cases—										
(a) Where complete cure or restoration of function (in the case of eye defect, full correction) is considered possible	307	9.4	168	7.3	146	6.1	10	3.2	631	7.6
(b) Where improvement only is considered possible, <i>e.g.</i> , without complete restoration of function	76	2.3	74	3.2	63	2.6	11	3.5	224	2.7
Total	383	11.7	242	10.5	209	8.8	21	6.7	855	10.3
Total number of children examined	3,267	100%	2,302	100%	2,386	100%	312	100%	8,267	100%

TABLE IV.

RETURN OF ALL EXCEPTIONAL CHILDREN OF SCHOOL AGE IN THE AREA.

DISABILITY	At Ordinary Schools	At Special Schools or Classes	At no School or Institution	TOTAL
1. Blind	—	3	—	3
2. Partially sighted—				
(a) Refractive errors in which the curriculum of an ordinary school would adversely affect the eye condition	—	1	—	1
(b) Other conditions of the eye, <i>e.g.</i> , cataract, ulceration, &c., which render the child unable to read ordinary school books or to see well enough to be taught in an ordinary school	—	9	—	9
3. Deaf—				
Grade I	483	29	—	512
Grade IIA	59	9	—	68
Grade IIB	—	20	—	20
Grade III	—	49	—	49
4. Defective Speech—				
(a) Defects of articulation requiring special educational measures	424	46	—	470
(b) Stammering requiring special educational measures	233	5	—	238
5. Mentally defective children (between 5 and 16 years)—				
(a) Educable (I Q. approx. 50-70)	—	201	—	201
(b) Trainable	—	64	—	64
(c) Ineducable	—	—	21	21
6. Epilepsy—				
(a) Mild and occasional	22	10	—	32
(b) Severe (suitable for care in a residential school)	—	—	—	—
7. Physically defective children (between 5 and 16 years)				
(a) Non-pulmonary tuberculosis (excluding cervical glands)	9	3	6	18
(b) General orthopaedic conditions	133	26	2	161
(c) Organic Heart Disease	123	4	2	129
(d) Other causes of ill-health	—	3	6	9
8. Multiple defects—				
(a) Mentally defective and deaf	—	7	—	7
(b) Physically defective and mentally defective	—	31	—	31
(c) Mentally defective (ineducable) and blind	—	1	2	3

TABLE V.—HEIGHTS AND WEIGHTS, 1933-1954.
Boys.

Year	GROUP I.—5 YEARS				GROUP II.—9 YEARS				GROUP III.—13 YEARS				GROUP IV.—16 YEARS			
	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.	Average Age	Average Height in Inches	Average Weight in Lbs.	
	5	3	40.5		9	0	49.7		58.6	16	0	65.7	123.9
1933-34	5	3	41.5	9	0	49.7	58.6	...	...	...	...	16	0	65.7	123.9
1934-35	5	3	41.6	9	0	49.7	58.0	...	...	...	...	16	1	66.4	128.7
1935-36	5	3	41.9	9	0	49.9	58.6	...	...	...	...	16	0	66.2	125.1
1936-37	5	3	41.8	9	0	50.0	58.8	...	...	...	...	16	0	65.4	126.7
1937-38	5	3	41.8	9	0	50.3	59.6	...	...	...	...	16	0	66.7	129.6
1938-39	5	3	42.0	9	6	51.3	60.9	13	6	58.6	90.9	16	5	67.7	135.0	
1939-40	5	4	42.3	9	6	50.9	61.3	13	6	58.5	89.8	16	6	67.0	134.1	
1940-41	5	3	41.9	9	4	50.7	60.8	13	5	58.4	88.2	16	4	67.1	132.0	
1941-42	5	4	42.0	9	4	50.8	61.1	13	4	58.3	88.3	16	5	67.4	133.2	
1942-43	5	3	42.0	9	4	50.8	60.8	13	4	58.5	88.8	16	5	67.5	134.0	
1943-44	5	3	42.0	9	5	50.9	62.0	13	5	58.6	89.4	16	7	67.4	134.7	
1944-45	5	3	42.2	9	4	51.0	61.8	13	4	58.4	89.4	16	4	67.5	133.5	
1945-46	5	3	42.4	9	5	51.0	62.2	13	5	58.7	90.1	16	6	67.5	134.3	
1946-47	5	2	42.3	9	2	51.1	62.0	13	5	58.7	90.4	16	6	67.6	130.0	
1947-48	5	2	42.3	9	5	51.1	62.4	13	4	58.7	90.6	16	6	67.5	134.5	
1948-49	5	3	42.4	9	5	51.3	63.3	13	5	58.8	91.4	16	6	67.7	134.3	
1949-50	5	3	42.8	9	5	51.6	63.6	13	5	59.0	91.6	16	6	67.6	135.3	
1950-51	5	3	42.5	9	3	51.5	63.1	13	5	59.1	92.5	16	5	67.4	133.3	
1951-52	5	3	42.7	9	4	51.3	63.0	13	5	59.9	93.1	16	5	68.0	136.3	
1952-53	5	3	42.5	9	4	51.6	62.9	13	7	59.3	93.3	16	5	68.3	132.3	
1953-54	5	3	42.3	9	4	51.5	62.9	13	5	59.6	93.7	16	6	67.7	133.6	

TABLE V.—HEIGHTS AND WEIGHTS, 1933-1954—continued.

Girls.

Year	GROUP I.—5 YEARS				GROUP II.—9 YEARS				GROUP III.—13 YEARS				GROUP IV.—16 YEARS			
	Average Height in Inches		Average Weight in Lbs.		Average Height in Inches		Average Weight in Lbs.		Average Height in Inches		Average Weight in Lbs.		Average Height in Inches		Average Weight in Lbs.	
	Yrs.	Mths.	Yrs.	Mths.	Yrs.	Mths.	Yrs.	Mths.	Yrs.	Mths.	Yrs.	Mths.	Yrs.	Mths.	Yrs.	Mths.
1933-34	5	3	41.2	38.8	9	0	49.7	56.6	...	...	16	1	62.7	115.4
1934-35	5	3	41.4	38.9	9	0	49.6	55.9	...	...	16	0	63.1	118.8
1935-36	5	3	41.3	38.5	9	0	49.6	55.9	...	...	16	0	63.6	118.8
1936-37	5	3	41.4	38.7	9	0	49.6	56.1	...	...	16	0	63.1	119.2
1937-38	5	3	41.7	39.1	9	0	50.1	56.8	...	...	16	0	63.8	120.7
1938-39	5	3	41.7	39.3	9	7	51.1	60.5	13	6	16	4	63.6	120.2		
1939-40	5	4	41.9	40.0	9	6	50.4	59.3	13	5	...	...	...	...
1940-41	5	3	41.7	39.7	9	4	50.2	58.5	13	5	16	6	63.6	120.5		
1941-42	5	3	41.6	39.8	9	4	50.3	58.6	13	4	16	5	64.0	122.3		
1942-43	5	3	41.8	40.0	9	4	50.4	58.2	13	4	16	6	63.9	120.6		
1943-44	5	3	41.6	39.9	9	5	50.4	59.4	13	5	16	7	64.4	124.8		
1944-45	5	3	41.9	40.1	9	5	50.3	60.5	13	5	16	6	63.6	123.8		
1945-46	5	3	41.7	40.3	9	6	50.6	60.4	13	5	16	6	63.1	121.7		
1946-47	5	2	42.7	40.2	9	5	50.7	60.3	13	4	16	6	64.2	124.2		
1947-48	5	2	42.0	41.2	9	5	50.8	60.6	13	5	16	5	63.8	123.2		
1948-49	5	3	42.4	41.1	9	5	50.9	61.5	13	5	16	5	64.0	123.9		
1949-50	5	3	42.1	40.7	9	5	51.0	61.3	13	6	16	6	63.9	120.9		
1950-51	5	3	42.1	41.0	9	5	51.4	61.1	13	4	16	6	63.9	120.3		
1951-52	5	3	42.0	40.8	9	5	51.1	61.4	13	5	16	6	63.8	123.6		
1952-53	5	3	41.9	40.5	9	5	51.0	61.2	13	5	16	6	63.9	123.4		
1953-54	5	3	42.0	40.8	9	4	50.8	61.5	13	5	16	6	63.8	123.2		

16.—PORT HEALTH ADMINISTRATION.

The Medical Officer of Health is also Port Medical Officer, with control of port health work and port sanitary work. A considerable portion of this work (*e.g.*, inspection of fish, fish premises, and boats) is carried out by the staff of the Sanitary Section of the Health and Welfare Department. Indeed, a District Sanitary Inspector is normally employed full-time on duties in connection with fish, and another Inspector devotes part-time to assisting him. A review of the work carried out by the sanitary inspectors will be given in the Annual Report of the Chief Sanitary Inspector.

The Public Health (Ships) (Scotland) Regulations, 1952, deal with measures to be taken by masters of vessels approaching ports if there is on board a suspected case of infectious disease or if the vessel has come from an infected port, and they also deal with the action to be taken by the Port Medical Officer in such circumstances. During the year, the usual declarations of health were received, and medical examinations were conducted in cases where they were deemed necessary. No particular difficulties were encountered, and no points call for special mention here.

17.—FOOD SUPPLY AND FOOD HYGIENE.

Ninety-four years have elapsed since the passing of the first Food and Drugs Act. In that period the control of food supplies by officers of local health authorities has gradually changed its direction. Although one still occasionally hears of water being added to milk or of cream being skimmed off, the gross adulterations of the past have now become rarities. Similarly, the more obviously unhygienic conditions of food production—the rat-infested, damp, insanitary underground bakehouse, for example—have, in the main, disappeared. In the examination of food samples, the bacteriologist is beginning to play a more important part than the biochemist, and in advice on the important subject of food hygiene it has become imperative that the medical officer take an active part instead of delegating this work entirely to the sanitary inspector. Also, since the biggest numerically handler of food is the housewife, it has become obvious that the district health visitor has a big part to play, perhaps the biggest part of all.

Excluding hygiene in the home, however, it is fair to say that, up to the present, much of the work—*e.g.*, in connection with milk and ice-cream—has been undertaken by members of the sanitary section. It will, therefore, be appropriate to omit further mention of these matters here and simply to indicate that the administration of the Acts, Orders, and Bye-Laws relating to milk, the details of milk samples examined during the year, and the administration of the Ice-Cream (Scotland) Regulations, 1948, will be outlined in the Annual Report of the Chief Sanitary Inspector. His report will also contain information about food premises inspected, defects found and remedied, and assessment of hygienic standards attained.

Mention may be made here of some points in connection with meat and other foods. Of the four private slaughterhouses licensed within the Burgh, two belong to the Flesher Incorporation, and all were in operation during the year, either continuously or intermittently.

The following is a summary of the animals slaughtered and the results of the inspection of the carcasses:—

Class of Animal.	Total Slaughtered.	Carcases totally Condemned.	Carcases partially Condemned.	Weight (in lbs.) of Condemned Meat and Offal.
Cattle	53,180	352	442	263,771
Sheep	146,845	247	162	27,053
Pigs	9,470	138	249	34,703
Calves	1,496	98	5	6,556
Other Animals	4	—	—	—
	<u>210,995</u>	<u>835</u>	<u>858</u>	<u>332,083</u>

In addition, 635 lots of organs or offal were condemned, and these weighed 109,893 lbs. The total weight of condemned meat and offal thus amounted to 441,976 lbs.

During 1954, there were no prosecutions under the Slaughter of Animals (Scotland) Act, 1928. Some seventy-four licences were issued for the use of the mechanically-operated instrument for the slaughter of animals.

The routine work necessary under the various Acts and Orders relating to Diseases of Animals was duly carried out. During 1954, there was no outbreak of swine fever.

During the year, no particular food hygiene campaigns were undertaken and no special action was taken in respect of general nutrition; but all members of the staff of the Health and Welfare Department—doctors, health visitors, sanitary inspectors, &c.—continued to exercise an educative influence on the public.

18.—SERVICES UNDER NATIONAL ASSISTANCE ACT, &c.

Some of the main developments of the year may be briefly summarised:—Following the appointment of a Principal Assistant Medical Officer in 1953, the tasks of developing and co-ordinating services for the physically handicapped and the elderly were entrusted to him. At the end of 1953, the Corporation decided to appoint a part-time social worker and to set up a register of physically-handicapped persons: by the end of 1954, some 333 names were already on the register, and a social worker and a specialist health visitor were fully occupied with assessing the needs of the cripples and with measures designed to meet these needs. As for the aged, during the year considerable progress was made with the register of old people and old couples living alone, visitation of the elderly by health visitors increased, supply of home helps to frail elderly persons was extended, the meals-on-wheels service provided by the W.V.S. underwent some extension, a fourth home for

persons no longer capable of maintaining an independent existence was opened, and preparations were made for the opening of two other homes.

General.

When the National Health Service (Scotland) Act, 1947, and the National Assistance Act, 1948, came into operation, the Corporation decided to combine the former Health Committee and Welfare Committee and to appoint the Medical Officer of Health as principal officer of a combined Health and Welfare Department. This decision made it unnecessary to seek to define in borderline cases the exact demarcation between after-care and rehabilitation; made it unlikely that a patient would be neglected while two departments argued about responsibility; made it improbable that patients would be subjected to the annoyance of visits by members of two separate departments; made it certain that advice on aspects of health and hygiene would be readily available to persons receiving welfare services; made such advice available in respect of buildings (*e.g.*, residential hostels); and, by avoiding duplication of records and of visits, allowed a better service to be given at a lower cost to the community.

In April, 1953, the Corporation appointed Dr. David Barclay as Principal Assistant Medical Officer, his main duties being to co-ordinate the varied services provided by the Corporation for the elderly, not only those in the Corporation's Homes but also those in their own homes; and to set up and co-ordinate services for the physically handicapped, including the deaf and dumb, the blind and partially sighted, and cripples. Under his supervision, these services have been developed considerably during 1954.

Provision of accommodation for elderly, &c.

Section 21 of the National Assistance Act, 1948, places on local authorities a duty to provide residential accommodation for aged and infirm persons who cannot adequately look after themselves but who do not require the skilled medical treatment or continuous nursing care available in a hospital. The whole conception of the type of accommodation required for such persons has completely changed; the bleak discomfort of the poor-law institution is rapidly being replaced by modern accommodation in homes which are comfortably furnished and conducted with a minimum of rules and which accommodate about 25-40 persons in each home. The aim is to make these old people comfortable, to rehabilitate them where possible, to make them look upon the home as their own home in the truest sense of the word, and to keep them interested and active members of the community. (The further and even more important point of trying to keep the majority of old people so healthy that they do not require institutional accommodation is considered elsewhere.)

When the Act came into operation, the only accommodation for the aged and infirm belonging to the Corporation was at Woodend Home. This (being quite unsuitable for active persons but capable of adaptation for hospital use) was sold to the Regional Hospital Board in 1951, although one of the conditions of sale was

that a portion of the accommodation would remain available for aged and infirm persons for a period of seven years.

During the 6½ years since the Act came into operation, the Corporation acquired or built hostels as follows:—

- (1) Balnagask House was acquired, suitably adapted, and opened (as a home for 25 persons) in December, 1950;
- (2) No. 3, Ferryhill Place, was acquired, adapted, and opened (as a home for 12 persons) in November, 1951; and in November, 1953, the adjacent property at No. 5, Ferryhill Place, having been purchased and adapted, the two houses were converted into a single home (with accommodation for 22 persons);
- (3) A home at Northfield, with accommodation for 40 persons, was opened by the Secretary of State for Scotland in April, 1953. This home is the first residential hostel for old people specifically erected by a Scottish local authority in conformity with the Act. Two of the main features of this home are the number of single bedrooms and the number of bedrooms on the ground floor. These will ensure an adequate measure of privacy for the residents and also that only the more active of the residents require to climb stairs;
- (4) No. 30, Albyn Place, was acquired, adapted, and opened (as a home for 24 persons) in February, 1954;
- (5) The Corporation has also acquired property at Newhills and Polmuir Road, and proposes to convert the former residential nursery at Thorngrove into another home. In addition, plans have been made for the building of a home at Ashgrove Road.

At the close of 1954, the accommodation already available was, therefore, 112 places, with a further 82 places in process of becoming available.

In addition, the Corporation has entered into an agreement with the Aberdeen Old People's Welfare Council, a voluntary body which has acquired four large houses for the reception of aged persons. By this agreement, the Corporation pay for the maintenance in these homes of Aberdeen persons who are financially unable to meet the charges personally. Similar arrangements have been made with the owners of the King Street Home for Girls, St. Margaret's Hostel, and with the Church of Scotland Committee on Social Service; these bodies receive into their homes certain aged and infirm persons who require accommodation which the Corporation cannot themselves provide, and the Corporation bears such proportion of the cost of maintenance as the persons are not able to meet.

At 31st December, 1954, the number of aged and infirm in residential accommodation (whether belonging to the local authority or to voluntary organisations) in respect of whom the Corporation make a contribution towards the cost of maintenance was as follows:—

Local Authority Homes—

	Male.	Female.	Total.
No 30, Albyn Place	6	15	21
Balnagask House	11	13	24
Nos. 3-5, Ferryhill Place	10	9	19
Northfield Lodge	8	27	35
Glenburn Wing of Woodend Hospital	61	54	115
<i>Voluntary Homes in Aberdeen—</i>			
Aberdeen Old People's Welfare Council	10	13	23
St. Margaret's Hostel	—	13	13
King Street Home for Girls	—	3	3
Church Homes	2	4	6
<i>Homes in other Areas</i>	<i>3</i>	<i>—</i>	<i>3</i>
Totals	111	151	262

Assessment of number of hostel places required.

According to the calculations of the Department of Health for Scotland and of the official report on "The Ageing Population" Aberdeen would require about 500 hostel places.

However, the Corporation's vigorous policy of providing services designed to enable old people to live happily and healthily in their own homes for as long as possible is already beginning to bear fruit. Accordingly, it is estimated that the City's requirement will be in the neighbourhood of 350 places, of which about 280 will be provided directly by the Corporation.

Medical Supervision in residential accommodation.

The Principal Assistant Medical Officer of Health pays periodic visits to the Corporation homes to supervise the hygienic aspects of each home and to give advice about diet, heating, ventilation, and so on. All the residents have a free choice of private doctor and receive personal medical care in the same way as do any other members of the community. This system works satisfactorily.

In 1954, as in past years, it has been necessary, owing to the deterioration in the condition of one or two residents, to have them transferred to the chronic sick wards of one of the hospitals. This has, so far, not caused any major difficulty but, if the present appreciable shortage of beds for chronic sick persists, some difficulty may arise in the future. However, it is hoped that, should any such difficulty be encountered, it could be overcome by a suitable two-way arrangement, whereby convalescent persons would be transferred from hospital to hostel and sick patients from hostel to hospital.

Cottages for the elderly.

The Corporation erected in the Kaimhill and Northfield areas, houses consisting of one room and a bedroom annexe together with a bathroom, for elderly couples. In certain other areas, the Corporation have erected similar types of houses and these houses have now been classified as special purpose houses and are not only for elderly couples but also for certain other classes.

General Provisions for elderly persons.

To keep elderly persons fit and healthy in their own homes is a task even more important than the provision of special hostels. It may be convenient to summarise here some provisions made by the Corporation for the health and welfare of the elderly in their own homes:—

(1) Visitation of the elderly by health visitors.—These visits are already proving particularly valuable, and the unification of the Health and Welfare Department is most helpful in that the health visitor (the person on whom rests the statutory duty of advising the whole family on many health matters) can bring her expert knowledge and experience to bear on the problems of the elderly individual. The health visitor's advice on diet, clothing, proper balance on rest and exercise, and on the development of leisure interests in preparation for retirement, can be of supreme importance in maintaining the health of persons of ripe years; and, where an old person is beginning to need assistance (*e.g.*, a home help, or the mobile service or chiropody) the health visitor can assess the need and initiate any necessary action. Again, when an old person becomes perplexed about the various possible allowances available to him, the health visitor can frequently remove his confusion.

It is interesting to note that only about one elderly citizen out of each hundred visited expresses himself as not desiring visits by health visitors. In these very exceptional cases, visiting is, of course, discontinued.

(2) Home Help Service.—The expansion of this service is described elsewhere, but it may be noted that an appreciable proportion of the home help service is devoted to old people, usually on a basis of two or three mornings per week per person. During 1954, 420 persons over 65 years of age received such assistance.

(3) Home Nursing Service.—This is described elsewhere, but 40 per cent. of cases dealt with by the district nurses on the day service and 75 per cent. of the cases of the nurses on the night service were persons of pensionable age.

(4) Chiropody Service.—This service, in which Aberdeen was a pioneer, is discussed in the section on care and after-care. By the aid of the chiropody service many old people who would otherwise have become housebound have been enabled to remain ambulant and capable of maintaining an independent existence.

(5) Meals-on-wheels Service.—This service is run by the W.V.S. and subsidised by the Corporation. During the year the Corporation paid £189 9s. 4d. for 5,684 meals supplied, as compared with £155 15s. 4d. for 4,673 meals in 1953.

(6) A register of elderly persons living alone and elderly couples living alone.—To facilitate co-ordination of the various statutory and voluntary services available for old persons it was decided during 1953 that a register should be compiled of all such persons brought to the notice of the department. As mentioned in the section dealing with prevention, care and after-care, by the end of 1954, the register contained about 800 names and had already begun to prove of great value.

WELFARE SERVICES (Section 29).

(a) Physically handicapped adults.

At the end of 1952, a scheme was drafted setting forth certain means whereby the Corporation could discharge its responsibilities for the welfare and training of cripples. The scheme was approved by the Secretary of State in 1953, and, in furtherance of it, handicapped persons were in December, 1953, invited by advertisement to register; a part-time social worker was appointed in January, 1954, and a specialist health visitor was allocated to this work in the same month.

During the thirteen months since the Corporation first invited physically handicapped adults to register as such, 336 persons have done so. Most of these persons registered in response to the original advertisements in the local Press, but some applications have also been received in the course of the year from people referred by their friends or by voluntary and public organisations interested in any Scheme to be proposed under this section of the National Assistance Act.

An initial visit has been paid to all applicants by the health visitor seconded for this duty or by the social worker appointed for this service. As a result, some major unsatisfied needs of this section of the community have been assessed and have been confirmed during the year when follow-up visits have been paid.

Locally, two important problems have emerged. One is unfortunately a situation which would require to be tackled nationally—that of appropriate employment for the physically handicapped. In Aberdeen it is most difficult for the Ministry of Labour to place disabled people in suitable light work as there is little light industry in the locality. Partly in connection with this problem is the second need—for an occupational centre, which would be of advantage both to those wishing but unable to obtain employment and to those who are unfit for work. Having discovered that approximately 140 of the people already registered would like (and would benefit from) such a centre, and knowing that there are many more physically handicapped persons in the City than have registered, the Corporation has decided to establish this type of centre which would obviate the despondency and feeling of uselessness to the community which these persons endure. It is not suggested that this would correspond to the satisfaction gained by working as a normal person but it would alleviate the position for those concerned by providing a meeting place where a variety of crafts could be learned and practised amongst people suffering similar disabilities. The search for suitable premises has gone on for several months but it is hoped that a building convenient for the purpose will soon be available. The Occupational Therapist who would be appointed for the centre would also be able to help in their own homes bedfast and housebound persons unable to attend at the centre. It has been found that the chronically ill when discharged from hospital have often little to occupy their time at home.

Innumerable smaller problems, not of less importance to the individuals concerned, have come to light. Often the advisory service has helped in small ways when people have not already known of existing services. The Health and Welfare Department has frequently acted as the liaison between these people and other

associations such as the National Assistance Board, the Ministry of Labour, Ministry of Pensions and National Assistance, the Youth Employment Officers, the Hospital Almoners and voluntary bodies.

The scheme being new, there is continual expansion in the sphere of activity especially where physically handicapped adolescents and young adults are concerned, and it is hoped that eventually the right niche for these youngsters will be found in society before they become (as in the past, because of their disability) a part of the hard core of the unemployed or unemployable.

The Local Authority has no power to make monetary payments to physically handicapped persons as the financial aspects are, in general, regulated by the Ministry of Pensions and National Insurance and by the National Assistance Board. It may, however, be noted that many ancillary problems of disablement can directly or indirectly be attributable to financial hardship of some degree. Persons in receipt of some of the National Insurance benefits over a period of years very quickly use up any savings because, as is generally realised, such benefits have been intended to "tide the recipient over" short spells of sickness or unemployment. When savings have been used the applicants have recourse to the National Assistance Board but its scales do not afford the pleasures of life. Frequently the physically handicapped persons are unable to pay for transport to and from friends' houses or to find money for any form of entertainment. They can also rarely take advantage of the usefulness of handicrafts at home because of the cost. The financial problem of a chronic illness in early or middle age may be similar to that of retirement but persons retiring at 60 or 65 years after a normal working life have in general made some provision for their change in circumstances. The younger unemployed disabled have rarely provided for the unexpected contingency of ill health and cannot hope to save anything at all for old age.

As will be understood, the Corporation will be doing its utmost to counteract social problems in this connection, but this side is, as with employment, essentially a big national problem, which cannot be solved by the efforts of a local authority.

It is an important factor and one which should perhaps be emphasised, that any service provided under this Scheme is complementary to, and in no way competitive with, other existing services. The Corporation has indeed been fortunate in gaining the co-operation of many other interested persons and organisations who are dealing in a different capacity with problems of the physically handicapped. The aim is always to fill in the gaps, coping with major problems as they arise, advising on the smaller ones and keeping close surveillance on constantly altering situations.

(b) *Blind Persons.*

A clinic for the examination and ascertainment of blind persons is held each month at Woolmanhill, and is staffed by two consultants employed by the North-Eastern Regional Hospital Board and by a health visitor employed by the Corporation. The Corporation carry out their responsibility for the blind under the Act through the agency of the Royal Aberdeen Asylum for the Blind, who provide training and employment in their workshops in Aberdeen, and the Aberdeen Association for the

Teaching of the Blind in their Homes, who employ home teachers for the training of the blind and provide certain welfare services. In addition, the Corporation utilise the services provided by certain other voluntary organisations. The following is a summary of the organisations and the payments made to them:—

Royal Aberdeen Asylum for the Blind.—For the financial year ended 31st May, 1954, the Corporation paid to the Royal Aberdeen Asylum for the Blind the sum of £193 6s. 5d. in respect of each City worker registered under the Disabled Persons (Employment) Act, 1944. There were 50 workers employed and the total cost to the Corporation was £9,666 7s., of this sum a grant at the rate of £100 per annum for each worker employed for a full year was recovered from the Ministry of Labour and National Service, making the net expenditure to the Corporation, £4,666 0s. 10d.

Aberdeen Association for Teaching the Blind in their Homes.—The sum of £3 15s. per annum is paid in respect of each certified blind person from Aberdeen on their roll. In addition, a grant of £20 per annum is made to the Association in respect of home workers who are assisted financially by the Association. At the end of the last financial year there were 268 certified blind persons on the roll, including 4 home workers, and the sum of £1,085 was paid by the Corporation to the Association.

Royal Blind Asylum, Edinburgh.—Two home workers are employed in Aberdeen, but are attached to the Edinburgh Home Workers' Scheme, and grant at the rate of £30 per annum for each of them is paid to the Royal Blind Asylum, Edinburgh.

Thomas Burns Homes, Edinburgh.—Two persons belonging to the City of Aberdeen reside in the Homes and are maintained by the Corporation. The net cost of maintenance for the two inmates during the year was £150 16s.

Book Production Grant.—£72 per year.

Donation to the National Library for the Blind.—£28 per year.

Holiday Home of the Edinburgh Society for the Blind, Ceres, Fife.—Although three persons were sent to this Home in 1952, the Corporation received no applications during 1954.

The number of blind persons on the Register of the Blind as at 31st December, 1954, was 345. The numbers according to the different age groups are as follows:—

0-2		3-4		5-15		16-17		18-29		30-39		40-49		50-69		70+		TOTAL		
M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	T.
—	—	1	2	3	2	1	—	6	4	14	9	19	24	52	69	51	88	147	198	345

During 1954, 50 persons were examined for the first time, 26 at the Blind Persons' Clinic and 24 at their homes. Re-examination was made of 18 persons.

The total number of persons examined was 68 as compared with 54 in 1953.

Of the 50 persons examined for the first time, 32 (or 64 per cent.) were certified blind within the meaning of the Blind Persons Act.

The following statement gives the number of blind persons of 16 years and upwards who were in employment at 31st December, 1954:—

	Males.	Females.
(a) <i>In Institutions for the Blind—</i>		
Undergoing industrial training	4	3
Undergoing secondary or professional education	1	—
In workshops	41	12
(b) <i>Outwith Institutions for the Blind</i>	11*	1

*Including 6 home workers.

Deaf and Dumb Persons.

Under the National Assistance Act, 1948, the Corporation are empowered to make provision for the training of deaf and dumb persons and also for their welfare. Pending the development of a fuller scheme, a payment of £435 15s. was made to the Aberdeen Deaf and Dumb Benevolent Society for the year 1953/54 in respect of certain welfare services provided by the society.

(d) Provision of temporary accommodation for persons in urgent need.

During the year temporary accommodation was provided for 31 persons in urgent need arising in circumstances which could not reasonably have been foreseen. In addition, enquiries were received from 260 other persons, and the services of the department were made available to them.

(e) Registration and Inspection of Homes for Disabled or Old People's Homes.

Under the National Assistance Act, no persons may open a home for the disabled and old persons without the home being registered by the appropriate local authority. During the year there were no further applications for registration, and the total number of Homes registered in the City is 8.

(f) Section 48—Care and protection of property of persons admitted to hospital or to local authority or voluntary hostels.

Care, protection, and storage was provided in 341 cases, in addition to handling, at the request of patients or responsible relatives, their varied contractual obligations while they were under care. This service performs a useful function by allaying distress and anxiety which, otherwise would retard the recovery of patients. In addition, 325 Old-Age Pensions were negotiated on behalf of pensioners during hospitalization and periods of accommodation to ensure the provision of extra comforts and to defray general personal commitments while under care or treatment.

(g) Section 50—Burial or Cremation of the Dead.

During the year, 55 persons—43 men, and 12 women—were dealt with under this Section.

(h) Reception Centre—Sections 17 (2) and 25 (1) (2), National Assistance Act, 1948.

By arrangement between the Corporation and the National Assistance Board, a Reception Centre has hitherto been provided at the "Gate House," Woodend General Hospital, to meet the needs of persons without a settled way of living.

During the year the male portion of the Reception Centre was transferred to a wing of the Municipal Lodging-House; and it is the intention that the female portion should be transferred to Newhills in 1955.

During 1954, accommodation was provided for males on 2,661 occasions, for females on 581 occasions, and for dependants on 38 occasions. The total of 3,280 occasions represents an average usage of 9 persons per night. (The corresponding figures for 1953 are 2,854 occasions, and an average usage of 8 persons per night.)

(i) *Removal of person by Sheriff's Order.*

Occasionally, persons are in need of care and protection in their own interests or in that of others but, although not certifiable under the lunacy acts, cannot be persuaded to enter a hospital or a residential institution. For such persons, it is possible to secure compulsory removal under Section 47 of the Act. This provision is a real necessity which must be interpreted with the utmost discretion and humanity, its provisions being utilised only after all powers of peaceful persuasion have failed. Dealing with such cases entails lengthy and patient visitation by experienced officers over a period of time in an endeavour to secure the peaceful co-operation of the person in need. The success of this mode of approach will be appreciated from the fact that, since 1948, the powers of this section have had to be invoked on only two occasions (in 1952 and 1954) and during the past twelve months peaceful persuasion achieved the acceptance of care and supervision in 21 cases where the need was really pressing. Such a need occurs not infrequently in cases of persons advanced in years and living alone, whose normal instincts for cleanliness, respectability, and order have become dulled by senility and advancing physical frailty.

19.—WORK UNDER NURSING HOMES REGISTRATION ACT.

The application which was under consideration at the end of 1953 was duly granted in 1954. It should be mentioned that a Home which had previously been registered, ceased to function as a Nursing Home as at 31st December, 1954.

20.—GENERAL SANITATION.

Most sanitary matters will be discussed in the annual report of the Chief Sanitary Inspector, but two points may be selected for mention here.

Water Supplies.

There is an ample supply of water for the City of Aberdeen, obtained from the upper reaches of the River Dee. The water is filtered and chlorinated. Samples of water are taken regularly from the Dee at Braemar, from intake at Cairnion, from filters at Invercannie, and from taps in the City. These samples are tested bacteriologically and biochemically. The results from all samples taken during the year were satisfactory.

River Pollution.

Pollution of the River Don from outside the City still causes anxiety, and has been the subject of special reports. The degree of pollution is such as to be highly objectionable, but it seems probable that no adequate remedial measures will be undertaken until a special Rivers Pollution Board is set up.

21.—STAFF AT 31st DECEMBER, 1954.

<i>Medical Officer of Health</i>	Ian A. G. MacQueen, M.A., M.D., D.P.H.
<i>Depute Medical Officer of Health</i>	Mabel E. Mitchell, B.L., B.Sc., M.D., D.P.H.
<i>Principal Assistant Medical Officer</i>	David Barclay, M.B., Ch.B., D.P.H.
<i>Senior Assistant Medical Officer</i>	Dorothy Younie, M.D., D.T.M. & H.
<i>Assistant Medical Officer (Schools)</i>	Henry J. Dawson, M.A., M.B., Ch.B., D.P.H.
	Mary Hunter, M.B., Ch.B., D.P.H.
	Sarah Lorimer, B.Sc., M.B., Ch.B., D.C.H. (on leave of absence).
	Jean C. Nelson, M.B., Ch.B., D.C.H., M.R.C.P.
	Margaret Ormiston, M.B., Ch.B., D.P.H.
	Jean Pattullo, M.B., Ch.B., D.P.H.
<i>Departmental Medical Officers</i>	Marie S. Sutherland, M.B., Ch.B., D.P.H.
	Doreen G. Warnock, M.B., Ch.B., D.P.H., D.R.C.O.G.
	Douglas M. Williamson, M.B., Ch.B.
	Margaret S. M. M'Gregor, M.D., D.P.H. (part-time).
	Mary Macdonald, M.B., Ch.B., D.P.H. (temporary replacement for Dr. Lorimer).
<i>Chief Dental Officer</i>	Archibald Hay, L.D.S., R.F.P.S. (Glasgow).
<i>Senior Dental Officer</i>	Vacant.
	Hugh Clunas, L.D.S.
<i>Assistant Dental Officers</i>	Ian Lawrence, L.D.S., R.F.P.S. (Glasgow).
	Mary K. Shepherd, L.D.S. (part-time).
	Isobel A. Ruddiman, L.D.S. (part-time).
<i>Public Analyst</i>	Alexander B. Weir, B.Sc., A.R.I.C.
<i>Day Administrative Officer</i>	Colin C. Grainger.
<i>Statistician (part-time)</i>	Doris M. Brebner, M.A., Dip.Ed.
<i>Superintending Nursing Officer and Supervisor of Midwives</i>	Jane A. Stark, S.R.N., S.C.M., Health Visitor's Certificate.
<i>Assistant Superintending Nursing Officer</i>	Lisetta J. Stephen, S.R.N., S.C.M., Health Visitor's Certificate.
<i>Health Visitors</i>	85 (including 24 vacancies).
<i>Midwives</i>	10 (including 1 vacancy).
<i>Principal Health Visitor Tutor</i>	D. Joan Lamont, S.R.N., S.C.M., Health Visitor's Certificate, Health Visitor Tutor's Certificate,

Assistant Health Visitor Tutor . . . M. Monica Byrne, S.R.N., Part I, C.M.B., Health Visitor's Certificate, Health Visitor Tutor's Certificate.

Student Health Visitors . . . 22.

Social Worker . . . Margaret Bell, B.A. (Admin.) (part-time).

Nurseries—

(a) RESIDENTIAL—

Pitfodels . . . Matron—Anne Adam, S.R.N., S.C.M., Health Visitor's Certificate, 2 Deputy Matrons, 7 Staff Nurses, 8 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 8 Nursery Assistants, 12 Probationer Student Nurses.

(b) DAY—

Charlotte Street . . . Matron—Margaret Moir, S.R.N., 1 Deputy Matron, 3 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 4 Nursery Assistants, 12 Student Nurses.

Linksfeld . . . Acting Matron—Alexina M'Leod, Certificate of Children's Nursing, 2 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 2 Nursery Assistants, 4 Student Nurses.

Deeside . . . Matron—Grace Florence, S.R.N., R.S.C.N., S.C.M., 1 Deputy Matron, 2 Staff Nurses, 2 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 6 Student Nurses.

View Terrace . . . Matron—Penelope Sandison, R.G.N., 1 Deputy Matron, 5 Certificated Nursery Nurses, 7 Student Nurses, 1 Probationer Student Nurse.

Old People's Homes—

BALNAGASK—

Superintendent and Matron . . . Mr. and Mrs. F. W. Gibson.

NOS. 3 AND 5, FERRYHILL PLACE—

Matron . . . Annabella M'Millan.

NORTHFIELD LODGE—

Matron . . . Elsie M. Cameron.

NO. 30, ALBYN PLACE—

Superintendent and Matron . . . Mr. and Mrs. H. T. Wallace,

Sanitary Section—

<i>Chief Sanitary Inspector</i>	Francis Thom, Sanitary Inspector's Certificate, Meat Certificate.
<i>Senior Assistant Sanitary Inspector</i> .	William Jackson, Sanitary Inspector's Certificate, Meat Certificate.
<i>Fish Inspector</i>	Sydney Howell, Sanitary Inspector's Certificate, Meat Certificate.
<i>District Sanitary Inspectors</i>	5 (including 1 vacancy).
<i>Assistant District Sanitary Inspectors</i> .	8 (including 3 vacancies).
<i>Apprentice Sanitary Inspectors</i>	2.
<i>Probationer Sanitary Inspector</i>	1.
<i>Shops Act Inspectors</i>	2.
<i>Senior Detention Officer</i>	William M'Donald, Meat Inspector's Certificate.
<i>Senior Assistant Detention Officer</i> .	William Lorimer, Meat Inspector's Certificate.
<i>Detention Officers</i>	4.

Welfare Section—

<i>Senior Assistant Welfare Officer</i>	James D. Davidson.
<i>District Welfare Officers</i>	3.

Clerical—

<i>Senior Clerical Staff</i>	E. B. Catto, Secretary to Medical Officer of Health; V. Anderson; M. M. Barry; A. G. Gall; C. P. Gibson; A. E. Munro; M. C. Veitch; M. A. Wilson.
<i>Other Clerical Staff</i>	General, 14; Clinics, 2; Dental Clinic, 2; Sanitary, 3; Welfare, 2.

Miscellaneous—

<i>Audiometrician</i>	Eileen N. F. Dowden.
<i>Orthoptist</i>	Vacant.
<i>Dental Attendants</i>	(including 1 vacancy).
<i>Male Visitor, School Health Service</i> .	1.
<i>Domestic Helps</i>	Full-time, 40; Part-time, 101.
<i>Lodging-house Superintendent and Matron</i>	Mr. and Mrs. D. Adam.
<i>Drivers and Porters</i>	3.
<i>Rat-catchers</i>	5.

